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THE CALIFORNIA HEALTH FACILITIES COMMISSION: A CASE STUDY OF GOVERNMENT REGULATION

PREPARED FOR THE HEALTH CARE FINANCING ADMINISTRATION,
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ALBERT J. LIPSON

R-2220-HCFA

NOVEMBER 1977

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PREFACE

The research reported here was begun during the summer of 1976. It was performed under Contract No. 600-76-0130 with HEW's Division of Health Insurance Studies, formerly part of the Social Security Administration and now part of the Health Care Financing Administration.

The issue of health facility cost containment has sparked considerable debate in Congressional and state legislative chambers. This study traces the fate of attempts by the State of California to regulate health facility costs. Its primary objective is to describe the political dynamics of health facility regulation in California as an aid to future policymaking.

SUMMARY

This study examines California's attempts to establish institutions and policies for containing health facility costs, a goal that has been elusive for both federal and state governments. The major themes of the study are summarized below:

1. The history of health facility regulation in California primarily reflects the response of a diverse and sophisticated hospital industry and allied health provider groups to changing cost-containment and political pressures in California.

Cost-containment pressures prompted the California hospital industry to sponsor legislation, enacted in 1971, creating the California Health Facilities Commission and empowering it to implement a mandatory accounting, reporting, and public disclosure system for hospitals. Some within the hospital industry hoped that the Commission would grow into a public-utility regulatory agency that would ensure the financial stability of hospitals while subjecting the industry to reasonable growth constraints. They believed that hospitals themselves should take the lead to initiate this regulatory scheme. They preferred state public-utility regulation, with the participation of hospitals, to federal price controls or "piecemeal" and "arbitrary" controls by government purchasers.

After temporary federal price controls were lifted in 1974, however, major hospital interest groups spurred by organized medicine chose not to initiate a rate regulatory program; instead, they adopted a posture of reaction rather than action as a political stratagem. They opposed rate regulatory proposals of the Commission and the Brown administration.

2. The positions of provider interest groups have reflected the diversity of California's health care industry.

California has over 600 nonfederal hospitals, more than 1200 nursing homes, and over 36,000 patient-care physicians. The largest segment of hospitals are nonprofit, more than one-third are investor-

owned, and the Kaiser Foundation Health Plan has about 2-1/2 million subscribers (about 12 percent of the state's population). While recognizing the desirability of presenting a common front on health regulatory matters, the various segments of the industry have sometimes clashed over regulatory policy. Physicians have generally opposed regulation, as have representatives of investor-owned facilities and Kaiser. Support for regulation has come primarily from the nonprofit segment of the industry, but in recent years those supporting regulation have been in the minority.

3. The unwillingness of the legislature either to expand or contract the Commission's powers in ways unacceptable to major health provider groups.

(The study does not assume that either expansion or contraction is desirable.) Efforts to expand the Commission's regulatory authority over health facilities, launched by both the Reagan administration in 1973 (SB 413) and the Brown administration in 1977 (AB 1156), were defeated largely because of effective industry lobbying, especially in the legislature's fiscal committees. Proponents of such powers apparently do not make up an effective constituency, and the legislature appears uncertain about the desirability of the proposed approaches, as evidenced by the announcement of the sponsor of the Governor's proposed legislation that he is dropping it in favor of a possible cost-containment initiative for inclusion in the November 1978 ballot.

The legislature has also been unwilling either to dismember the Commission or to expand the rate-regulatory powers of the Department of Health--both moves opposed by health provider groups.

4. The influence on the Commission of the gubernatorial administration during which it functioned.

The Commission was created, nurtured, and given added authority under the Reagan administration. It was designated State Advisory Board to advise on exemptions from federal price controls. It was part of the Reagan "team."

After the election of Governor Brown, the Commission was neglected at first and the Governor did not make authorized appointments to it (Phase I). The Brown administration then proposed eliminating the Commission, which thereupon entered a battle for survival (Phase II). Finally, after failure to phase it out, the administration took control of the Commission by making appointments to it (Phase III).

The "new Commission" differs markedly from its predecessor. For the first time it has a majority of public members, several of them affiliated with consumer advocacy groups. The Commission has sought consumer-group input to its deliberations and has taken a more activist role in support of consumer interests.

5. The lack of involvement and interest by consumer groups in the Commission's work until recently.

The creation of the Commission was sparked in part by the activity of a labor-sponsored health group, the Council for Health Plan Alternatives (CCHPA), which lobbied for health facility regulation in the late 1960s. However, consumers paid little if any attention to the Commission's efforts to implement its statutory mandate to design a uniform accounting, reporting, and disclosure system for hospitals and long-term-care facilities. This left the way clear for provider groups to exercise virtually unchallenged primary influence over Commission activities during its early years.

6. The competition between the Commission and Department of Health for regulatory power.

These agencies struggled for control over health facility regulation and data collection. The Department won designation as the State Certificate of Need Agency but failed in its effort to gain authority to regulate facility rates and conduct a federally sponsored rate regulatory study. Moves to expand the Department's powers received little legislative support.

7. The effect of federal government actions on the development and implementation of state health regulation.

Federal actions imposing or proposing price controls, mandatory Certificate of Need programs, limits on hospital rates, and regulatory studies have set the parameters for state action and have been important determinants of the positions of interest groups. They have both stimulated and complicated state decisionmaking.

The seven major conclusions of this study are:

- *The health facility regulatory process involving the Commission as a key participant was biased toward health provider interests, but it is not clear that this has resulted in socially undesirable outcomes.*

The Commission fulfilled its primary task of producing a generally well-regarded accounting and reporting system; and as for cost containment, there is no assurance that the proposed programs the legislature failed to enact would have been efficacious anyway. Appointments in 1977 by Governor Brown have markedly reduced pro-industry bias.

- *It is unlikely that California will enact major cost-containment legislation in the near future.*
- *California should be cautious about enacting comprehensive regulatory legislation in this complex field.*
- *The state can play a major role in developing and aggressively disseminating health facility data, conducting studies of hospital productivity, experimenting with alternative cost-containment strategies, and focusing public attention on cost-containment issues.*
- *Consumer involvement can help counterbalance the influence of providers in the health facility regulatory process.*
- *Future cost-containment efforts should involve physicians because they make the major decisions that generate medical costs.*
- *The implementation of California's uniform accounting, reporting, and public disclosure system should be independently evaluated.*

ACKNOWLEDGMENTS

The preparation of this report required the cooperation of many people associated with the California health industry and government regulation of it. We are especially grateful for the assistance of the members and staff of the California Health Facilities Commission, particularly its former Executive Director, Robert Murch, and its present Acting Executive Director, Gordon Cumming.

Critical comments by Rand colleagues Richard Rettig and George Eads helped to structure the form and substance of the final version of this report. Arturo Gandara prepared an analysis of the Commission's statutory authority. Al Williams also made a number of constructive suggestions. These acknowledgments do not relieve the author from responsibility for errors that may remain.

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Chapter 1
INTRODUCTION

PURPOSE OF THE STUDY

Pressures to contain rising hospital costs prompted the hospital industry to sponsor legislation, enacted in 1971, that created the California Health Facilities Commission.[1] The Commission had limited powers at first; its primary responsibility was to implement a mandatory accounting, reporting, and public disclosure system for hospitals. Some people viewed the Commission's initial charter as a first step toward public-utility-like health facility controls, but their expectations were not to be fulfilled. Attempts to expand the Commission's role to include regulation of facility rates as well as capital expenditures and services (CES) have been unsuccessful. (CES controls are aimed at curtailing excess community facilities and services through prior-approval mechanisms.) Unsuccessful attempts have also been made to eliminate the Commission by transferring its functions to the State Department of Health. The embattled Commission's powers therefore remain essentially what they were in 1971, except for inclusion of long-term-care facilities under its regulatory mantle.

This study describes how the Commission implemented its statutory mandates, but goes beyond the Commission itself to examine the politics of health facility regulation in California. It focuses on legislative action that resulted in the Commission's creation and the defeat of proposals to either expand or contract its role. It weighs the influence of health-provider interest groups on both Commission and legislative behavior. It portrays the Commission as buffeted about by major forces in its political environment, including the two

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[1] Originally called the California Hospital Commission, 1973 amendments renamed it the California Health Facilities Commission. Throughout this report the word "Commission" refers to that body under either of its names.

gubernatorial administrations during which it functioned and the State Department of Health, which competed with it for regulatory power. The study seeks answers to such questions as:

- o What driving forces led to the creation of the Commission and subsequently influenced its behavior?
- o Was the Commission biased toward health care providers in general and hospitals in particular?
- o Why did efforts to change its role fail?
- o How did it fare under the administrations of Governors Reagan and Brown?

Essentially, this is the story of how California confronted the issues of health facility cost inflation, in the context of political conflict and change and under conditions of uncertainty about the effectiveness of government regulatory approaches to cost containment.

RELEVANCE OF THE STUDY

President Carter's special message to Congress on April 25, 1977 called for a 9 percent lid on hospital cost increases as a first step toward more permanent reorganization of the health care reimbursement system. He said this step was necessary to stem the tide of inflation in the cost of health care, which had jumped 1000 percent since 1950, is now growing 15 percent a year, and has risen "so rapidly it jeopardizes our health goals and our other important social objectives."[2]

Shortly after President Carter's announcement, California's Governor Edmund G. Brown, Jr., announced introduction of his own plan to control "skyrocketing" costs of health care. He pointed out that these costs consume a growing share of our gross national product (from 4.6 percent in 1950 to 8.6 percent in 1976, and projected to be 10 percent by 1981). He said, "It's time to put a limit, a lid, to

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[2] Statement by the President to the Press on the same date as the special message to Congress.

provide some orderly control in this runaway inflation that is rampant throughout the hospital industrial complex here in California."[3]

These announcements highlighted renewed interest by both federal and state governments in the issue of growing health care costs and how to contain them. The role of the states is a central issue in current federal legislative deliberations on President Carter's program. It is likely that the issue of health facility cost regulation will command public attention for some time while both federal and state governments experiment and search for better ways to contain health care costs. Governmental interest in cost containment is not new, however. Federal planning laws, culminating in the National Health Planning and Resources Development Act of 1974 (PL 93-641), have sought to contain facility cost growth by CES controls, and the federal government imposed price controls in 1972 that lasted through April 1974 for the health industry. Also, as HEW Secretary Joseph Califano pointed out at the announcement of President Carter's program, "The states are leading the way here. It is not a situation the federal government is going into without any prior experience."[4]

A number of states have established regulatory mechanisms for hospital cost containment. A survey by the American Hospital Association (AHA) indicates that 25 states, excluding California, have some type of rate regulatory program affecting over 2000 hospitals and almost 1500 nursing homes, and 13 other states, including California, are contemplating one. In five states such regulatory authority is exercised by a commission (Connecticut, Maryland, Massachusetts, Oregon, and Washington). In other states programs are administered by either a state department, a Blue Cross plan, or a state hospital association.[5] A 1974 survey showed that 24 states,

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[3]Transcript, Joint News Conference of Governor Edmund G. Brown, Jr., and Assemblyman Barry Keene, May 9, 1977, p. 1. A local Sacramento newspaper quoted an unnamed source who characterized the Governor's move as "an attempt to out-Carter Carter." *Sacramento Bee*, May 9, 1977.

[4]Press Briefing, April 25, 1977.

[5]American Hospital Association, *Report on Rate Regulatory Programs*, January 1977.

including California, have enacted Certificate of Need laws aimed at preventing a disapproved facility from operating. In three states, Certificate of Need and rate regulatory authority are exercised by the same agency. PL 93-641 requires all states to have a Certificate of Need program within four years.

States face many complex challenges in their efforts to set up hospital cost containment mechanisms. Little is known about hospital production functions (i.e., the combination of resources required to produce certain outputs). There is disagreement about how best to control hospital cost growth and dispute about the effectiveness of alternative regulatory approaches. Regulatory bodies are often faced with conflicting mandates to curb cost increases but not to reduce the availability or quality of care. Meanwhile, they lie at the eye of the political storm, since their actions could affect the fortunes of both health care providers and consumers.

Although many states have set up governmental units to regulate hospital financial affairs, little is understood about the forces and influences that motivated the creation of these units and shaped their development. We hope to draw lessons from California's experience that will be useful to California decisionmakers, other states, federal officials, and the public at large.

The remainder of this chapter discusses the Commission's organization and powers, briefly describes its history, and outlines the study's approach and method.

ORGANIZATION OF THE COMMISSION

The Commission is an independent entity in California state government. It is separate from the agencies and departments that administer the major ongoing programs of state government.[6] Although

[6]The executive branch of the State Government is organized into four cabinet-level agencies which, with the Department of Finance, report to the Governor and coordinate the activities of separate departments on his behalf. (See App. A for an organization chart of the executive branch.)

the Governor appoints its members, they serve fixed four-year overlapping terms and, unlike agency administrators or department directors, they cannot be removed at his pleasure. Also, unlike department budgets, the Commission's budget is submitted directly to the Department of Finance for inclusion in the Governor's Budget and is not subject to direct review and approval by agency administrators as are the budgets of departments within their agencies.

The Commission is a small agency. Its 1976-77 fiscal year (FY) expenditures totaled under $1 million. Its staff, headed by an Executive Director, consisted of fewer than 30 people and included only 18 professionals, as of October 1976. (See App. A for an organization chart of the Commission.) By comparison, the Department of Health (DOH) has a budget of over $3 billion and staff of over 20,000, and the Public Utilities Commission a budget of more than $20 million and a staff of over 850. All Commission decisions are made at meetings open to the public. This contrasts with decisionmaking by administrative agencies, most of which are not required to make their determinations in public view.

PROVISIONS OF THE CALIFORNIA HEALTH FACILITIES DISCLOSURE ACT

Legislative Intent

In enacting the California Health Facilities Disclosure Act the Legislature declared it be the policy of the State (emphasis added):

> . . . to require all *health facilities* . . . to *file* . . . for *public disclosure* with the California Health Facilities Commission . . . such *uniform reports* of health facility *cost experience* in the provision of health care services . . . in accord with the *systems of accounting approved* . . . for all of the following purposes [Sec. 441(a)]:
>
> (1) Encouraging economy and efficiency in their provision of such services in this state [Sec. 441(a) (1)].
>
> (2) Enabling *public agencies of this state* which purchase health care services under, or which have administrative responsibility for, publicly financed health care plans or programs to make informed decisions in such purchasing or administration [Sec. 441(a) (1)].

> (3) Encouraging public and private third party payors for health facility services to take the information . . . into account in establishing reimbursement rates to assure health facilities of a fair and reasonable payment for such services rendered.
>
> . . . that health facilities are *affected with the public interest*, involved in the distribution of essential services, and obliged to furnish services to the general public at fair, equal, and non-discriminatory rates [Sec. 441(c)].

The Commission

The Governor appoints the 15-member Commission with the advice and consent of the Senate. A majority of the members (8) are required to be public representatives and a minority (7) are to be chosen from the health industry with the following qualifications (Sec. 441.3):

- One with at least five years experience in health insurance or in the administration of a health care service plan.
- One with experience managing a comprehensive group-practice pre-payment health care service plan.
- Four executive officers of health facilities, one each from a nonprofit hospital, an investor-owned hospital, a nonprofit skilled nursing home, and an investor-owned nursing home.
- One physician with at least five years practice in the state.

The Commission chairman and vice-chairman are elected by the Commission. The chairman must be one of the public members. Commissioners receive $100 per day plus expenses for official activities. The Commission must meet at least three times annually in designated parts of the state.

The Commission is permitted to contract for services, and must submit an annual report to the Governor and the legislature.

The Advisory Council

An 11-member Advisory Council, created to assist the Commission, is composed of:

- Three public members, one of whom is required to be a labor union representative and another an accountant with at least five years experience, for auditing health facilities.
- Five members representing investor-owned, county, university, district and nonprofit facilities. These members are to be appointed from nominees of organizations representing these facilities.
- Three members, one representing a nursing home, one serving at the pleasure of the Director of Health, and one a physician with five years practice in the state.

Advisory Council members are appointed by the Commission for three-year terms. They serve without compensation except for reimbursement for expenses and must meet at least twice a year. The Council advises the Commission upon request. It must be consulted, however, on proposed Commission regulations and on approved accounting and reporting systems (Secs. 441.9 and 441.14) and it must approve Commission special studies (Sec. 442.2).

Commission Staff

The Executive Director is appointed by and is responsible to the Commission; 1977 legislation removed the requirement that he or she have at least two years experience as a hospital administrator. The Commission is also empowered to appoint its own attorney, who serves at the Commission's pleasure.

The Accounting and Reporting System

After holding public hearings, the Commission is required to prepare and distribute approved systems of health facility accounting and uniform reporting.

With the aid of those systems, every health facility subject to the act is required to file five major financial reports (Sec. 441.18):

(1) A balance sheet detailing assets, liabilities, and net worth at the end of its fiscal year.

(2) A statement of income, expenses, and operating surplus or deficit for the annual period ending on the balance sheet date.

(3) A statement detailing the source and application of funds expended by the health facility for the period encompassed by the income statement.

(4) A statement reporting the information required above for each separately licensed health facility operated, conducted, or maintained by the reporting organization.

(5) A report on expenditures that allocates the costs of non-revenue-producing departments of a health facility to the other non-revenue and revenue-producing centers that they serve.

Each facility must also submit a detailed *statistical report* that identifies costs related to categories, types or units of health care services delivered to patients.

In lieu of the reports required by the Commission, the facilities are permitted to file cost and statistical reports required by the Social Security Administration in its administration of Title 18 (i.e., the Medicare program).

The Commission is mandated to establish reporting provisions for health facilities that receive a preponderance of their revenue from group-practice prepayment service plans (e.g., Kaiser health plan).

Public Disclosure

Reports filed by hospitals with the Commission are available to the public, as are reports prepared by the Commission. All governmental units are encouraged to use these reports in establishing policies and procedures regarding reimbursement rates.

Other Commission Powers and Duties

The Commission was also empowered to:

- Set up approved systems of health facility accounting, uniform reporting, and auditing, to create "to the extent feasible" one uniform, comprehensive state system that takes into account the data requirements of all state programs and to make data available to other state agencies (Sec. 441.6 (c)).
- Develop for submission to the legislature no later than July 1, 1975, a Health Facility Economic Stabilization program "to retard inflationary increases in health facility costs and prices." The program was intended to replace the federal wage-price stabilization program if terminated or federal delegation occurred (Sec. 441.14).
- Take actions conferred upon it or the states by the federal Cost of Living Council or the Federal Wage Price Stabilization Program (Sec. 442.11).
- Conduct special studies, with the approval of the Advisory Council, to advance the purposes of the act including studies of methods to implement "cost-effectiveness programs" for delivery of health services (Sec. 442.2).

Enforcement

Health facilities not filing required reports on time are fined $100 for each day of delay.

Financing

The California Health Facilities Disclosure Act establishes a California Health Facilities Commission Fund in order to fund the Commission's activities. Fees are assessed as follows: 0.05 of 1 percent for skilled nursing facilities and intermediate care facilities, and, for other health facilities, not more than 0.02 of 1 percent of their gross operating costs for the provision of health care services for their last fiscal year. The Commission must establish the fee each year to produce revenues equal to the Commission's appropriation in the Budget Act for the current fiscal year. A health facility not paying required fees will not be licensed (Sec. 442.10).

Extensions, Hearings, Review

The Commission is empowered to grant extensions. Aggrieved parties may petition for a hearing before a Commission appeals committee. Commission decisions are final, subject to judicial review under the Code of Civil Procedure (Sec. 442.5).

COMMISSION HISTORY

Appendix B presents a chronology of important events affecting the Commission. The following is a brief review of the Commission's history.

On September 9, 1970, the Board of Trustees of the California Hospital Association (CHA) called for the creation of a hospital financial reporting system; it then urged the passage of legislation establishing a public agency with powers to prescribe ways that hospitals keep their books and require disclosure of income and expenditures.

The CHA acted largely in response to pressure for control of hospital costs and to industry concern that rate-setting for public programs (i.e., Medi-Cal and Medicare) was arbitrary and unreasonable (e.g., reimbursement rates were lower than charges to nongovernment patients).

The concern over hospital costs was not new. In 1960 the Governor's Committee on Medical Aid and Health had proposed a hospital planning system; 1969 legislation (AB 1340, Duffy) set up a state Certificate of Need program. Some industry leaders urged public utility regulation of hospitals. Pressure was put on hospitals in 1970 in the form of labor-sponsored rate-regulatory legislation (SB 1359, Beilenson) and legislative cost containment hearings. In developing its program, CHA sought the advice of an expert in public utility regulation, Professor Fred Morrissey, who recommended uniform financial data collection as a necessary first step to future regulation. CHA-sponsored legislation (SB 283) was introduced by Senator Stephen Teale (D-West Point) on February 15, 1971. Entitled the Hospital Disclosure Act, the bill generated only

mild controversy when Kaiser hospitals unsuccessfully sought complete exemption from its provisions. SB 283 was passed in 1971 and became effective in 1972. It established a uniform accounting, reporting, and disclosure system for California hospitals and created the 7-member California Hospital Commission.

Governor Reagan made Commission appointments in 1972, and designated it as the State Advisory Board (SAB) under Phase II of the national economic stabilization program, with responsibility to review and make recommendations on exceptions from the 6-percent price rise ceiling imposed on all health care providers.

During its first two years, the Commission set about establishing regulations and an accounting manual for hospitals, with assistance from the CHA. The Commission's reporting system became effective in July 1974. One-third of California's more than 600 hospitals were required to file reports by the end of October 1975, another one-third by April 1976, and the rest by the end of 1976. The first annual inventory of hospital financial and statistical information was published by the Commission in the spring of 1977.

Early in 1973, the Reagan administration sponsored a bill (SB 413, Beilenson) that would have expanded and reorganized the Commission's responsibilities to include rate setting and approval for new health care facilities (i.e., Certificate of Need) and also reorganized area comprehensive health planning agencies. SB 413 was enacted only after amendments made it applicable solely to facility licensure (see Chap. 7).

The Commission's responsibilities were greatly expanded in 1973 and 1974, however. AB 2123 (Hayden), sponsored by the CHA and enacted in 1973, required the Commission to report to the 1975 legislature on a proposed economic stabilization program for hospitals to replace the federal wage-price stabilization program. It also authorized the Commission to accept federal delegation of price control authority and to establish a single comprehensive, uniform health facility data system for the state. AB 4396 (Ingalls), proposed by the California Association of Health Facilities (CAHF) and enacted in 1974, mandated a Commission-

administered uniform accounting and reporting system for nursing homes and intermediate care facilities, thereby expanding its jurisdiction to include 2000 health facilities. Under AB 4396 the Commission was renamed the California Health Facilities Commission and its membership was enlarged to 13. AB 1812 (Murphy), sponsored by the California Association of Homes for the Aging (CAHA) in 1975, further enlarged its membership to 15.

The nursing home accounting system initially proposed by the Commission met with major industry opposition in 1975. Opponents complained that it was inappropriately based on a "medical model" and was too complex and costly for long-term care facilities to administer. It was modified to meet their major objections.

The Commission's economic stabilization program report (mandated by AB 2123), developed after two years' study with the assistance of CHA, was presented to the 1975 legislature after the election of Governor Brown. The CHA had taken the initiative to develop its own government regulation program by establishing a task force, which made recommendations in 1974. The Commission held hearings and set up a Rate Review Subcommittee to help formulate its program. The Commission recommended that its powers be expanded to include rate regulation and Certificate of Need controls. Significantly, the Commission's legislative program was launched after federal price controls on hospitals were lifted in the spring of 1974 and industry support for state rate controls had declined. Its recommendations were embodied in SB 1107 (Beilenson), which received no support from either the Brown administration, which viewed it as provider-oriented, or from health providers. Symbolic of the Brown administration's attitude toward the "holdover" Commission was its failure during 1975 and 1976 to make previously authorized additional Commission appointments. Instead of the Commission-backed legislation, AB 4001 (Keene) was enacted in 1976 giving a Certificate of Need program to the DOH.

Other Commission-sponsored legislation (SB 1108, Beilenson) failed to pass in 1975, in the face of DOH opposition. It would have authorized the Commission to contract with the Social Security Administration (SSA)

under federal legislation (PL 93-641) authorizing tests of rate-setting activities in six states where there was legislative intent to regulate rates.

In 1976 both the Commission and the DOH submitted competitive proposals to the SSA for prospective rate-setting studies in California. The Commission appointed a Task Force on Short and Long-Range Objectives in June 1975 to help develop its proposal. The Task Force report proposed a hospital budget, rate-review, and approval method, but also contained recommendations--opposed by the industry--that an industry-wide cost-growth target be set and that unneeded hospitals be phased out. After submitting its proposal to SSA, the Commission modified these recommendations.

The DOH proposal used a formula rate-setting approach; it was endorsed by state agencies on recommendation of the Department of Finance. The SSA awarded funds to the DOH for the project, but the legislature would not allow state or federal funds to be spent on the project, and thus killed it.

Another casualty in the same struggle was the CHA-supported PIPE project (Prospective Incentive Payment Experiment), which proposed a regional demonstration to test new payment methods. As initially conceived, the project would have used the Commission as rate-setter but, after the Brown administration took office, the CHA reversed its position and proposed a rate-setting body appointed by the Director of Health. The SSA decided that the CHA project would not be funded if the DOH project failed.

After concluding that the DOH's rate-study proposal was superior to the Commission's, the Department of Finance began to question whether the Commission was needed at all, especially since its duties conflicted with those of the DOH. Partly basing its decision on a Department of Finance study, the Brown administration proposed in 1976 that the Commission be phased out and the DOH assume its powers and duties. Previous studies by the state's Little Hoover Commission and the DOH had also called for the Commission's dismemberment. A major justification for eliminating the Commission, cited in all three

reports, was that its health facility data-collection duties overlapped with those of the DOH. Both agencies struggled to control health facility data. The Commission sought to implement the health facility data provisions of AB 2123, and the DOH sought to serve its own program needs. Their differences became irreconcilable when the DOH refused to cooperate with the Commission, and both agencies competed for designation as the single operating agency under the federal program.

In the legislature, the Commission actively fought both the DOH's SSA project and the administration's recommendations to phase it out. It was aided by legislative antipathy toward the DOH stemming in part from investigations of prepaid health plan administration, unexplained deaths in state mental health institutions, and dissatisfaction with DOH management. In 1977, after killing the DOH's SSA project, the legislature also restored the Commission's budget. Governor Brown then made the long-delayed Commission appointments. The new Commission, with a number of public members associated with consumer advocate groups, adopted a mission statement in August 1977 supporting a system of public-utility-like health facility regulation and an aggressive public disclosure program. After the announcement of President Carter's national hospital cost-containment program (HR 6575, S 1391), the Brown administration also sponsored rate regulation legislation (AB 1156, Keene) that would reorganize the Commission and establish a formula rate-setting method. This went down to defeat after opposition by all major provider groups, who further urged that the state wait until Congress acted on the President's program. Assemblyman Keene thereupon announced that he was dropping the bill in favor of a cost-control initiative measure he would seek for the November 1978 ballot.

In response to widespread dissatisfaction with the administration of state health programs, the legislature passed a Brown administration-supported bill (SB 363, Gregorio) to break up the DOH into six units. It also enacted an administration-backed proposal--opposed by health providers--to narrow exemptions in the Certificate of Need law

(AB 245, Berman), and enacted a Commission-backed bill to remove the requirement that the Commission's Executive Director be a hospital administrator (AB 348, Maddy).

STUDY APPROACH

This is in large measure a study of the Commission's interaction with its political environment, including (1) the interest groups that sponsored its creation and were primarily affected by its activities (hospitals, medicine, insurance, consumers); (2) the state legislature and two gubernatorial administrations (Reagan and Brown), which substantially determined its powers and duties; (3) the state agencies that either worked or competed with it (the Departments of Health and Benefit Payments, and the Health and Welfare Agency); and (4) the federal agencies that influenced and complicated its role (by imposing and lifting price controls, mandating Certificate of Need laws, authorizing hospital rate-setting studies, and collecting state health facility data). The dynamic interactions between the Commission and these forces in its environment shaped its behavior. Some influences were more significant than others, of course. This study explores several governing themes that encompass all of the major factors:

- *The response of a diverse and sophisticated hospital industry and allied provider groups to changing political pressures and pressures for cost containment.*

Given pressure from government and consumers to "do something" about facility cost growth, would provider groups fight or acquiesce to increased government regulation? Would they seek to promote regulatory patterns to protect and promote their own interests? The hospital industry's initial response to these pressures was its proposal to create the Commission with limited authority.

Predictably, after the legislature validated the industry-backed proposal to set up the Commission, provider groups sought to influence its implementing actions. They also promoted legislation to expand its role in ways they found acceptable and opposed those expansion measures they found unacceptable.

- *The positions of provider interest groups on important cost containment issues, reflecting the diversity of California's health care industry.*

Provider groups have not always presented a monolithic united front. Various segments of the California hospital industry (e.g., nonprofit, investor-owned, Kaiser prepaid group practice, and Catholic affiliated hospitals) have taken differing positions on issues affecting their vital interests as have other provider groups such as physicians and long-term-care facilities. Also, their positions have been modified over time and have been influenced by changes in California's political and regulatory environment. In this study we examine how provider groups responded to cost containment pressures, by documenting their positions on cost containment legislation and issues and their efforts to influence the Commission.

- *The unwillingness of the legislature to either expand or contract the role of the Commission in ways unacceptable to major health provider groups. (We do not assume that either action is or is not desirable.)*

Proposals backed by both Governors Reagan and Brown, and opposed by key provider groups, to expand the role of the Commission to include CES controls and rate regulation, respectively, were defeated in the legislature. Moreover, a proposal backed by Governor Brown to phase out the Commission was also defeated. These actions, among others, suggest the strong political influence of health provider groups in the legislature and the inability or unwillingness of supporters of

increased regulation of health facilities to mobilize a constituency able to counteract predominant industry influence. They also suggest that part of the legislature's unwillingess to enact rate regulation stems from the complexity of cost containment issues and uncertainty about whether proposed regulatory measures would in fact achieve socially desirable results. In this study we examine the development and fate of various proposals to change the Commission's legislative authority.

- o *The influence on the Commission of the two gubernatorial administrations during which it functioned.*

The Commission was established under the Reagon administration. Initial appointments to it were made by Governor Reagan, who designated it as the State Advisory Board under the federal economic stabilization program. During his administration legislation was enacted expanding the Commission's powers. Although it was independent and not a "line" agency of the executive branch, the Commission was accepted by and regarded as part of the Reagan administration.

Governor Brown's administration was unfriendly to the Commission. He refused for two years to make appointments to it and unsuccessfully sought its elimination. But then, in a significant policy reversal, he made the appointments and initiated a major proposal to reorganize the Commission and give it rate-regulatory power over health facilities.

- o *The lack of involvement and interest by consumer groups in the Commission's work until recently.*

A consumer of health care has an immediate interest in the cost, quality, and availability of care. The consumer is also a taxpayer and a direct or indirect purchaser of care, primarily through the health insurance system (e.g., as a member of a labor union or other employee group plan).

It is difficult for most consumers, however, to organize to promote their collective interests in the cost of health care. Not only are the issues complex, but it is difficult to measure the personal benefits derived from support of organized activity as compared with those derived from other leisure-time pursuits. Health providers, in contrast, have a vital economic stake in the outcome of government regulation and therefore support professional associations and lobbyists to look after their interests. Despite the difficulty of organizing consumer groups, a number have been active in health matters. However, they paid little attention to the Commission's work until representatives of consumer organizations were recently appointed to the Commission by Governor Brown. This study examines the activities of consumer organizations interested in the Commission's work.

- *The competition between the Commission and the DOH for regulatory power.*

When the Commission was first created with limited regulatory power, it constituted no threat to the DOH, but the two agencies soon entered a political and bureaucratic struggle over who would administer CES and rate regulation, and control health facility data. Their conflict is described herein.

- *The effect of federal government actions on the development and implementation of state health regulation.*

Federal legislation imposing economic controls, planning requirements, and reimbursement systems has altered the environment in which state action has taken place. It has opened opportunities for state regulation, constrained choices available to the states, and complicated state decisionmaking.

Political scientists have formulated the "capture" theory of regulation, which holds that important interest groups exercise control of the legislative and administrative process and that, over time, regulatory agencies become dominated by the regulated industry.[7] Economists have suggested that this behavior can best be understood by examining the economic benefits derived by such groups from the regulatory process.[8] According to the political economy theory, as described by Noll, the regulatory process is biased toward satisfying well-represented economic interests who have strong voices before regulatory agencies and the legislature. Even though regulators may try to serve the public interest, they perceive it in an environment of uncertainty and competition among conflicting interests. In this milieu they assess the success of their performance either by how other governmental bodies, such as courts and legislatures, treat their decisions and influence their powers and funding (e.g., are decisions reversed, authority curtailed, budgets cut?) or by the effects of their decisions on the regulated industry (e.g., is the industry hurt economically? Are those most directly affected by regulatory decisions supportive of them?). Industry interests are promoted not only by appointment of industry representatives to regulatory bodies but also by industry investment in legislative lobbying and capable presentation of industry views before these regulatory agencies. To avoid disputes or reversals, the regulatory body will most likely make compromises favoring those most interested in their decisions and most likely to appeal or fight a ruling. Pro-industry bias is reinforced by political gain in the form of campaign

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[7] The group process theory was developed primarily by A. F. Bentley and D. B. Truman. M. Bernstein, S. Huntington, A. Leiserson, and H. Ziegler extended this to regulatory bodies. For a discussion of theories advanced to explain government regulation of the economy, see R. A. Posner, "Theories of Economic Regulation," *The Bell Journal of Economics and Management Science*, Vol. 5, No. 2, Autumn 1974, pp. 335-338.

[8] G. J. Stigler suggested that regulation is "acquired by an industry and is principally designed and operated for its benefit." See "The Theory of Economic Regulation," *The Bell Journal of Economics and Management Science*, Vol. 2, No. 1, Spring 1971, pp. 3-21.

contributions for those who support industry positions. Groups that are usually unorganized, such as consumers, ordinarily are not represented before such agencies, which are commonly ignored by the public and the political system.[9]

Applying this theory to the Commission, one would expect it to be biased toward the health care industry generally and toward hospitals and nursing homes in particular. *One central thesis of this study is that the health facility regulatory process, in which the Commission is a key participant, has been biased toward provider groups.* This is not to say that such bias is socially undesirable, but merely that it exists. In this report we examine the nature, extent, and consequences of pro-industry regulatory bias. Analysis of provider interest-group influence alone, however, is insufficient to fully explain the dynamics of the health facility regulatory process.

METHOD

Our analysis was based on data collected by the following methods:

1. *Direct personal interviews* with people and organizations involved in the creation and activities of the Commission. Over one hundred interviews were conducted with 91 people associated with the Commission and representing all major organizations directly interested in the Commission's work.

2. *Review of the Commission's record* contained in regulations and reports issued by the Commission, minutes of Commission meetings and meetings of advisory groups and task forces, transcription of public hearings held by the Commission on its economic stabilization program, and newspaper and periodical accounts.

3. *Review of the record of major agencies and organizations* that influenced or were influenced by Commission actions. They

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[9] See Roger G. Noll, "The Consequences of Public Utility Regulation of Hospitals," in *Controls on Health Care*, National Academy of Sciences, 1975, pp. 25-48, and *Reforming Regulation*, The Brookings Institution, pp. 33-46.

include the California Hospital Association; the United Hospital Association; Kaiser Foundation Health Plan, Inc.; Blue Cross plans in Northern and Southern California; the California Association of Health Facilities; the California Association of Homes for the Aged; the California Medical Association; the Health Insurance Association of America; the California Council for Health Plan Alternatives; the California Conference for Comprehensive Health Planning; the California Health and Welfare Agency; the State Department of Health, including the units concerned with comprehensive health planning, the state Medi-Cal program, rates and fees, facilities and licensing, and health statistics; the State Department of Finance, and the Task Force on the Health Department of the State Commission on Economy and Efficiency (The Little Hoover Commission). The record has included public statements before the Commission and correspondence, internal memoranda, and reports.

4. *Review of the record of the California State Legislature* on major legislation affecting the Commission, including bills introduced, amendments, statements by legislators, memoranda and correspondence prepared by legislative staff, including the Office of the Legislative Analyst, and appropriate transcribed public hearings.

5. *The author's attendance at public hearings* affecting the Commission, and other direct observation of important Commission activities.

6. *Review of literature* concerning controls on health care costs, cost containment activities in other states, and periodical literature concerning the Commission.

Interviews

Interviews were held with all members of the Commission (prior to Governor Brown's recent appointments), staff and members of its Advisory Council, and representatives of all major interest groups involved in its work. (See App. C, "Interview List.")

Interviews held between August 1976 and May 1977 were structured to fit the particular background of the interviewee and his or her organizational affiliation. The interviews were designed to determine:

1. Critical events and issues affecting the Commission.

2. The nature of interactions between the Commission and the health care industry, particularly those indicating the presence or absence of pro-industry bias.

3. The treatment of the Commission under both the Reagan and Brown Administrations.

4. Commission interactions with the DOH.

5. The effect of Commission actions on the health care industry.

6. Key legislative decisions affecting the Commission.

To promote open and free discussion, many persons interviewed were promised confidentiality. Notes were made after each interview and in the majority of cases they were sent to the interviewee for verification, correction, or comment. These interview notes are on file at Rand. To protect personal privacy we have not quoted anyone directly without their permission. In many cases citations in our report refer to interviews with Commission members and staff, DOH officials, California Hospital Association staff, or persons by group affiliation. The names of individuals in these groups are listed in App. A. This method attributes the viewpoint to a group without revealing interviewees. In other cases we have quoted people directly with their permission. This approach achieves a reasonable balance between scientific validity and personal privacy.

Limitations

Our study *does not evaluate* the effects of public disclosure of hospital financial data. It would be premature to do so since financial data have only recently been disclosed, and it was beyond the scope of our study to perform such an evaluation.

As with any case study, it is difficult to generalize the results of a study of one institution to the behavior of similar bodies, but it is hoped that this study will enrich our understanding of institutions like the Commission.

OUTLINE OF THE STUDY

Chapter 2 sets the context for succeeding chapters by describing characteristics of the California hospital industry and interest groups involved in the Commission's work. Chapters 3 through 9 are self-contained discussions of major Commission-related activities; the reader's indulgence is requested for the repetition to be encountered there, since those chapters approach the Commission's history from differing perspectives. For those not interested in fine detail, a summary is appended to each chapter. Chapter 3 examines industry influence on the health facility regulatory process and its effects, and discusses Commission actions that reflect a pro-industry bias. Chapter 4 presents a detailed examination of the driving forces behind the initiation and passage of the Hospital Disclosure Act that created the Commission. Chapter 5 discusses the implementation of hospital disclosure and the Commission's role as State Advisory Board under the federal economic stabilization program. Chapter 6 portrays the genesis and implementation of nursing home regulation by the Commission. Chapter 7 retraces legislative efforts to expand the Commission's role and to enact CES controls during both the Reagan and Brown administrations. Chapter 8 reviews the conflict between the DOH and the Commission, especially their struggle for control of health facility nonfinancial data. Chapter 9 describes the Commission's successful battle for survival in the face of Brown administration efforts to phase it out of existence. Chapter 10 summarizes the study's major findings and conclusions and discusses their implications.

Chapter 2
THE CALIFORNIA HEALTH FACILITY INDUSTRY AND PRESSURES FOR COST CONTAINMENT

This chapter discusses the pressures behind proposals to contain hospital costs in California, describes the characteristics of the health facility industry, and presents a preliminary review of Commission organization, legal powers, and history.

COST-CONTAINMENT PRESSURES

Trends

Several trends have stimulated cost-containment pressures in California.

o *Hospital expenditures have been soaring.* They doubled between 1970 and 1975, from $2.16 billion to $4.32 billion, while per capita expenditures rose over 90 percent (from $107.66 to $209.25).[1] Total national expenditures also doubled, from $19.6 billion to $39 billion, and per capita expenditures rose 90 percent, from $96 to $184.

o *The number of hospital beds is climbing.* The number of California hospital beds per 1000 population has grown by one-third since 1960 (from 2.94 to 3.92); national growth was 28 percent (3.55 to 4.55).[2]

o *The number of unoccupied hospital beds is also climbing.* California's occupancy rate has been lower than the national average and the gap has been widening. The 1975 occupancy rate was 66.6 percent, compared with 75 percent for the U.S.[3] According to the most recent Commission data, California's occupancy rate is 59.1 percent. The California Auditor General reports that "excess"

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[1] California Hospital Association, *Hospital Fact Book*, Table 3, p. 4.

[2] Ibid., Table 24, p. 33.

[3] Ibid., Table 9, p. 12, Table 12, p. 16.

hospital beds grew over 70 percent between 1971 and 1976, and that elimination of 20,000 of them would save $400 million a year.[4]

o *The average cost per patient day and per admission in California hospitals is higher than the national average.* For California, 1975 costs per patient day were $217, but $151 for the U.S.; costs per admission were $1437 and $1165, respectively. Among ten industrial states, California ranks fifth in costs per admission.[5]

o *State Medi-Cal expenditures have increased dramatically.* They have more than quadrupled since Fiscal Year (FY) 1968-69 (from over $300 million to $1.4 billion in 1977-78).[6]

Causes of Cost Growth

A recent HEW-sponsored study of state and regional health regulation concluded that the basic supply, demand, and resource programming decisions in the health field are made by health care professionals who have few incentives and many disincentives to strive for economic efficiency.[7]

Recent studies have suggested that administrators seek to enhance the prestige of nonprofit hospitals by increasing their size and quality, and that hospital expansion serves the economic interests of staff physicians. The obvious results are hospital growth and increased demand for hospital services.[8]

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[4] *Hospital Bed Capacity*, Report of the Auditor General No. 283, Feb. 1977, pp. 2-7. The report used the California State Plan for Health estimates of need to determine excess and estimated that an unoccupied bed costs $20,000 per year.

[5] Ibid., Table 5, p. 6; Table 6, p. 8; and Table 8, p. 12.

[6] 1977-78 Governor's Budget, State of California, unnumbered table on p. 605.

[7] Lewin and Associates, Inc., *An Analysis of State and Regional Health Regulation Part 1*, Report of the Study, February 1975, pp. 1-3.

[8] See J. P. Newhouse, "Toward a Theory of Non-Profit Institutions: An Economic Model of a Hospital," *American Economic Review*, Vol. 60, No. 1, March 1970, pp. 64-74, and Mark Pauly, "Alternative Models of Non-Profit Hospital Monopolies," in C. Havighurst (ed.), *Regulating Health Facilities Construction: Proceedings of a Conference on Health Planning, Certificate of Need and Market Entry*, American Enterprise Institute, Washington, D.C., 1974.

A number of scholars agree that the public's seemingly limitless demand for medical services for which they do not pay directly, fed by huge infusions of public funds, has led to the allocation of an ever-growing share of our national wealth to pay for medical care,[9] an increase whose societal value is questionable.

Responses to Cost Growth

The need for cost containment is widely recognized, but there is no consensus on the best ways to attain it.

Pressures to regulate hospital rates come primarily from government purchasers, alarmed at seeing a larger and larger slice of their annual budgets going to hospitals for Medicare and Medi-Cal payments. Without cost containment, however, reducing government payments would impose an indirect tax on other purchasers who are billed for services the government does not pay for.

Some segments of the hospital industry favor public utility status for hospitals, contending that the government and other third-party payors should meet hospitals' financial requirements and pay the same rate for the same services. Some scholars contend, however, that such a step would not contain costs and could produce perverse results. They favor structuring of market incentives to restore "the cost consciousness of beneficiaries" and encourage the formation of health maintenance organizations.[10]

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[9] See M. S. Feldstein, *The Rising Cost of Hospital Care*, Information Resources Press, 1971; C. C. Havighurst (ed.), *Regulation of Health Facilities Construction*, American Enterprise Institute for Public Policy Research, 1974; *Public Utility Regulation for Hospitals*, Reprint No. 17, American Enterprise Institute, August 1973; *Controls on Health Care*, Papers of the Conference on Regulation in the Health Industry, National Academy of Sciences, 1975.

[10] C. C. Havighurst, "Controlling Health Care Costs: Strengthening the Private Sector's Hand," *Journal of Health Politics, Policy and Law*, Vol. 1, No. 4, Winter 1977; Paul M. Ellwood, Jr., "Alternatives to Regulation: Improving the Market" in *Controls on Health Care* (see footnote 9).

In an interview, one hospital leader complained that emphasis on hospital regulation is misplaced

> because the government has promised more than it can deliver and is unwilling to cut back on services. Rather than go after the doctors who control the delivery of services and are politically powerful, they chose to go after less politically powerful hospitals and nursing homes. They are trying to pressure these institutions to cut back without dealing with the entire health system.

Spokesmen for some segments of the California hospital industry claim that cost regulation is not necessary in California because the average hospital stay is only 6.6 days compared with 7.7 for the U.S., and admissions per 1000 population are 144 versus 158 for the U.S.[11]

CHARACTERISTICS OF THE HEALTH FACILITY INDUSTRY

Several characteristics of the California health facility industry affect the organization and activities of interest groups seeking to influence governmental action.

o *It is large and diverse.* California has over 600 nonfederal hospitals (9 percent of the U.S. total), and it has over 1200 skilled nursing homes that spend more than $5 billion for annual operations (hospitals spent $4.5 billion in 1975). Half of California's hospitals and three-fourths of its nursing homes have fewer than 100 beds. These facilities provide medical care at the direction of California's more than 36,000 patient-care physicians.

o *California hospitals are predominantly nonprofit, but a large share are investor-owned.* (See Table 2.1.) Fully 40 percent (49 percent of licensed beds) are nonprofit, and 36 percent (23 percent of licensed beds) are investor-owned. California, with 10 percent of

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[11] *Hospital Fact Book*, Table 6, p. 8, and Table 9, p. 12.

Table 2.1

NONFEDERAL HOSPITALS IN CALIFORNIA

Type of Hospital	Number		Licensed Beds	
County/city		57		15,951
District		62		6,553
Investor-owned				
Individual	5		99	
Partnership	19		2,535	
Corporation	193		19,615	
Total, investor-owned		217		22,249
Nonprofit				
Church	29		6,322	
Corporation	188		38,041	
Other	21		3,486	
Total, nonprofit		238		47,849
Prepaid plans		27		4,942
Total, all hospitals		601[a]		97,544

SOURCE: *California Health Facilities Commission: First Annual Inventory of Financial and Statistical Information for California Hospitals, Fiscal Periods Ending June 30, 1975-June 29, 1976.*

[a]Total excludes 17 hospitals required to file with the Commission but whose reports had not been completed by February 1, 1977, and 12 state hospitals with 22,554 beds.

the nation's population, has 30 percent of its investor-owned hospitals. Such hospitals account for 35 percent of community hospitals in California, but only 13 percent in the nation. Also, 90 percent of skilled nursing homes are investor-owned.

o *California has the largest prepaid group practice health services plan in the nation.* More than 4 percent of hospital facilities and 5 percent of hospital beds provide services to prepaid plan subscribers, the largest of which is operated by the Kaiser Foundation. Kaiser has about 2-1/2 million California subscribers (about 12 percent of the State's population).

o *Federal, state, and country governments combined pay for more than half of hospital care in California. In the nongovernment market, commercial carriers insure more than twice the number of patients as do Blue Cross/Blue Shield plans.* The federal government paid for 37 percent of hospital care through Medicare and Medi-Cal programs. County governments paid for 8 percent, and state government 7 percent.[12] A 1971 study of the payment status of 205 short-term nonfederal hospitals in California revealed that more than 28 percent of hospital stays were paid for by commercial insurance and 12 percent by Blue Cross/Blue Shield plans.[13] The market shares of commercial carriers and Blue Cross plans very substantially by state. In contrast to California, for example, Blue Cross plans in New York, Massachusetts, and Pennsylvania account for two-thirds of total health insurance benefit payments.

Insurance carriers have been threatened with elimination from the health insurance market by proposals for a national health insurance program.

The foregoing characteristics of California's health facility industry have several implications for the behavior of interest groups. First, its large size and wide distribution imply economic power that

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[12]California Health Facilities Commission: *First Annual Inventory of Financial and Statistical Information for California Hospitals.*

[13]M. L. Ingbar, Hospital Costs and Efficiency, University of California, San Francisco, June 20, 1973, Table 35, p. 3.

is translatable into political influence. Second, the diversity of facility ownership suggests a diversity of interests. For example, investor-owned facilities are likely to be concerned with profits for shareholders, nonprofits with prestige and growth, and prepaid group service plans with survival and growth in a fee-for-service market. Third, the size of government payments suggests a predominant interest by government in keeping costs and budgets in line. Fourth, the nature of the insurance market suggests that competition will intensify between commercial insurance and Blue Cross plans for a larger share of the insurance market (and so will support by private carriers for government-regulated equal rates to eliminate Blue Cross discounts) and, perhaps more important, that further growth of government programs threatens to eliminate them from the health insurance business.

We can anticipate that the health facility industry will defend its economic interests before the California legislature and regulatory agencies such as the Commission.

INTEREST GROUPS

By far the most important interest group in our study is the California Hospital Association (CHA), which includes about 560 hospitals. The largest single CHA membership group consists of nonprofit hospitals (45 percent) followed by investor-owned facilities (32 percent). County, university, federal, and municipal hospitals account for the rest. CHA is affiliated with the American Hospital Association (AHA).

About 165 investor-owned facilities are represented by the United Hospital Association (UHA), an affiliate of the national Federation of American Hospitals (FAH). CHA, UHA, and the Kaiser Foundation Medical Care Program maintain lobbies in Sacramento, as does the more recently organized California Association of Catholic Hospitals (42 facilities).[14] County hospitals are represented through the County Supervisors Association of California (CSAC).

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[14]This association began to take positions on legislation in 1975 and has been interested in Certificate of Need, rate regulation, and moral issues of concern to Catholics.

Organized medicine is represented by the 25,000-member California Medical Association (CMA). CMA makes substantial campaign contributions through its political action committee (CALPAC), and is regarded as one of the most powerful interest groups. Professional societies, representing hospital-based physicians such as radiologists, pathologists, and anesthesiologists, also take a direct interest in Commission activities.

Long-term-care facilities have two interest groups that have participated in the Commission's work. Investor-owned facilities, which dominate the nursing home industry, are represented by the California Association of Health Facilities (CAHF), which has about 800 member institutions with 72,000 beds serving the aged, convalescent, and chronically ill. It is affiliated nationally with the American Health Care Association. The small number of nonprofit long-term-care facilities are represented by the California Association of Homes for the Aging (CAHA), serving 200 homes.

Commercial health insurance has been represented by the Health Insurance Council of the Health Insurance Association of American (HIAA), which underwrites about 80 percent of U.S. commercial health insurance. The two California Blue Cross plans (Northern and Southern California) have their own Sacramento representatives. Nonprofit Blue Cross Plans have about 4 million California subscribers.

Until recently, organizations representing consumers have paid little attention to the Commission's administrative activity, although a group representing organized labor participated in the development of legislation creating the Commission. This group, the California Council on Health Plan Alternatives (CCHPA), was set up in 1969 as a voluntary organization composed of labor organizations throughout the state with about two million members. CCHPA was suspended in 1974, when unions decided to concentrate their activities on National Health Insurance. CCHPA membership included state and local AFL-CIO and Teamsters organizations, as well as independent locals representing water works employees, carpenters, longshoremen, steelworkers, and culinary workers.

Created in 1975, the Consumer Health Coalition is a statewide consumer volunteer organization whose interests are allied with those of other consumer-oriented groups, such as Accountants for the Public Interest, the Western Center on Law and Poverty, and the Health Rights Organization.

Chapter 3
HEALTH FACILITY REGULATION: INDUSTRY INFLUENCE AND ITS EFFECTS

INTRODUCTION

A number of scholars aver that the regulatory process, by its very nature, is biased in favor of the regulated industry. This chapter addresses the question: Was the health facility regulatory process in which the Commission was a key participant biased toward the CHA and allied health provider interests? If so, what difference did this make and who was responsible for it? How were Commission powers, policies, and actions affected? Were industry interests promoted? Did socially undesirable outcomes result?[1]

As we refer to it here, the health facility regulatory process consists not only of the behavior of the Commission itself but also the full range of major interactions between the Commission and its regulatory environment, including (1) actions of the legislature that established the Commission and subsequently determined its powers and duties; (2) appointments to it and its relationships with the gubernatorial administration in power; and (3) the Commission-related activities of major organizations inside and outside the government that had a stake in its activities (e.g., the CHA and other interest groups, the Department of Health (DOH), etc.).

We employ the term "bias" here to denote a predilection for or inclination toward support of provider interests in general, and hospitals (represented by CHA) in particular. It connotes a bent, based on experience, to favor a certain point of view. A finding of bias in the health facility regulatory process does *not* mean that the Commission was a puppet of the industry or that bias necessarily produces socially undesirable results. On the other hand, one cannot

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[1]This section focuses primary attention on Commission activities prior to Governor Brown's March 1977 Commission appointments.

disprove bias by citing isolated examples of disagreement between the Commission and health providers. Bias is merely a general tendency to favor. We suggest the following hypothetical conditions as a basis for determining bias toward the regulated industry (primarily meaning hospitals, and secondarily toward nursing homes and medicine). They serve to establish the industry's motive, means, and opportunity to dominate the Commission, and enable one to judge the success of its efforts:

1. Industry interests were *served* by creation of the Commission and subsequent expansion of its powers and duties. This condition establishes both motive and success.

2. The interaction between the Commission and the industry was *cooperative* and *nonadversarial*.

3. The industry had a *vital stake* in the Commission's activities.

4. The Commission served its *own interests* by serving industry interests; its "success" depended heavily on industry support and cooperation.

5. The industry had the *opportunity* to exercise its influence on the Commission through the structure and procedures established by law and the appointment process, and was heavily involved in decision-making.

6. Identifiable *methods* were successfully employed by industry to exercise its influence, including lobbying both in the legislature and with the Commission.

7. There were no significant *countervailing pressures* to offset industry influence, either from executive branch agencies, consumer groups, the legislature, or Commission staff.

8. The industry was *perceived* as dominating the Commission by interviewees from such key groups as CHA, the DOH, the Legislature, others who worked with the Commission, and Commission members and staff.

INDUSTRY INFLUENCE

Having sponsored creation of the Commission, the hospital industry had a heavy stake in both its immediate and future actions and powers, as did nursing homes once they came under the Commission's jurisdiction. The short-run interests of medicine concerned only the activities of hospital-based physicians; their long-range interests concerned the existence of more elaborate controls by government over medical services provided in hospitals, and, potentially, the doctor's office, if some form of future control were exercised over physician fees.

Major industry groups, particularly the CHA, had much to gain or lose by the actions of the Commission. The CHA was interested in how the Disclosure Act mandates would be fulfilled. It had a much greater stake in potential expansion of Commission authority into rate regulation and CES controls.

Legal Requirements

The law creating the 7-member Commission required that it be composed of a hospital administrator, a physician, a manager of a group practice prepaid health plan, a health insurer, and three public members representing consumers.

The law also required that the Executive Director of the Commission be a hospital administrator, which further subjected the Commission to industry influence.

By law, the Commission's Advisory Council was also composed primarily of industry representatives, who had to be consulted on all important Commission decisions. The law also established the Commission as an independent entity, outside the direct control of executive branch agencies and therefore largely free from influence by appointees of the Governor responsible for so-called line departments. The administration could exercise direct power, of course, through the appointment of Commission members and through budgetary controls.

The law required industry financing of the Commission. Although funds provided from industry assessments were appropriated annually by the legislature, the fact that industry pays the bill lends credence to the view that industry interests should at least be heard. Also, funds from the industry are less susceptible to budget manipulation than are general funds. If industry financing is a means of industry influence at all, it is probably more subtle than direct.

Methods of Influence

The CHA and other provider groups used a variety of methods to exert their influence on the health facility regulatory process and on the Commission:

- They initiated and designed the legislation creating the Commission.
- The CHA was consulted on the first appointments to the Commission and helped to recruit the Commission's Executive Director. Current members of the Commission include the President of the California Medical Association and the President-elect of the American Hospital Association.
- Hospitals invested heavily in representing industry interests before the Commission.
- Hospitals lent abundant technical assistance to the Commission. They helped it develop a uniform accounting and reporting systems for hospitals, a state economic stabilization program proposal, a Social Security Act hospital rate study proposal, and a system for health facility nonfinancial data collection.

Provider groups bestowed social recognition and prestige, particularly on public members, by entertaining them, inviting them to speak at industry functions, and giving them publicity.

Industry and Commission Interests

Because the Commission depended heavily on industry support, its interest was usually served by working cooperatively with the CHA, whose support encouraged industry compliance with Commission mandates.

The CHA's interests were served by initiation of the Disclosure Act, which the industry designed primarily to promote acceptable and block unacceptable regulation. CHA's interests were also served by expansion of the Commission's role in ways supported by the hospital industry.

CHA backed successful legislative efforts to enlarge the Commission's responsibility to implement federal price control authority if delegated to the state, and to develop a state economic stabilization program. It preferred state regulation, exercised by an independent Commission with industry representation, over federal regulation. CHA favored expansion of the Commission's data collection responsibility to reduce data demands on hospitals and to place control of facility data in the hands of an independent Commission sympathetic to industry concerns.

COUNTERVAILING PRESSURES

Countervailing pressures against industry influence can emanate from the administration in power, other groups interested in hospital cost containment, the DOH, the legislature, or the Commission's staff.

Reagan Versus Brown

Close relations prevailed among the Reagan administration, the Commission, and the CHA, although the hospital industry did not unanimously support the administration's efforts to expand the Commission's role through SB 413.

Under Governor Brown those relationships became much more complex. There were three phases of interaction between the Brown administration and the Commission. At first the Commission was neglected (Phase I); then the administration proposed its elimination, and the Commission had to fight for survival (Phase II); and finally, after

failure to phase it out, the administration took control in March 1977 by making long-delayed appointments to the Commission, whereupon the situation entered an entirely new phase (Phase III). Brown's appointment of consumer activists sympathetic to the administration not only brought the Commission close to the administration but also made industry leaders wary. Their influence on the Commission declined. Public members gained a majority and the new Commissioners immediately sought active participation of consumer groups in their work. An indicator of divergence between the new Commission and providers was the Commission's September 1977 mission statement favoring an activist and expanded role, adopted over the objections of industry members.

The Legislature

Although some legislative staff have participated in the Commission's implementation tasks, most legislators have paid little, if any, attention to them. In interviews, key legislators and staff most heavily involved with health legislation perceived the Commission as industry dominated; and it does appear that the unwillingness of the legislature to expand or contract the Commission's role under both the Reagan and Brown administrations reflects the political influence of health provider groups; however, it also reflects the lawmakers' uncertainty about the effectiveness of proposed cost containment methods. A similar lack of legislative confidence in the DOH helped kill attempts to expand the DOH's role into rate regulation and to assume Commission functions. Finally, weak countervailing pressure by interest groups supporting expanded regulation left providers with a relatively clear field to pursue their legislative objectives.

Commission Staff

The Executive Director and other staff members sometimes made suggestions that would have placed additional implementation

burdens on the industry and were opposed by industry spokesmen. Most of these suggestions were rejected either by the Commission or the Advisory Council.[2] Commissioners interviewed said they were more inclined to turn to industry for technical advice than to their own staff.

As noted, interviews with Commission staff indicate how they perceived themselves in a service role to the hospital industry. Overall, it does not appear that staff were effective in countervailing industry influence.

PERCEPTIONS OF INDUSTRY INFLUENCE

People's perceptions of industry influence ranged widely, from industry domination to lack of influence. Most of those interviewed saw the hospital industry, and particularly the CHA, as the primary group influencing Commission decisions.[3] This was before Governor Brown made his appointments in March 1977. This view was shared by most Commission members and staff, industry spokesmen, staff of executive agencies, insurance groups (commercial and Blue Cross), legislative staff, and consumers interested in the Commission's work. As expected, those serving in executive branch agencies (e.g., the DOH) were more inclined than others to suggest industry "domination." The perceptions of DOH staff probably should be discounted, since at least some of them would tend to stress industry domination to discredit a Commission with whom they were competing for regulatory power. Also, as expected, consumers and Commission "public members" were more apt to emphasize industry influence than were industry spokesmen and health-provider Commissioners. One public member of the Commission

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[2]For some examples see passages herein on disclosure implementation. A staff suggestion that the Advisory Council's "veto power" over special studies be reversed was turned down by the Advisory Council partially on the grounds that the Council could prevent "politically motivated or ill-conceived" special studies on hospital costs. Commission Minutes, July 21, 1976.

[3]See Appendix C for names and affiliation of persons interviewed.

resigned in the fall of 1976, issuing an especially strong statement in which she criticized Governor Brown for failure to make Commission appointments and charged that this failure continued industry's domination of the Commission. She said that "as long as the Commission is dominated by a majority of industry representatives, that industry only will be considered."[4]

Industry spokesmen, who might be expected to stress Commission independence of industry influence, nevertheless acknowledged the primacy of industry influence. Several industry interviewees even suggested industry "domination" of the Commission. Most of them stressed cooperation between industry and the Commission, and the Commission's willingness to listen to the industry view and give the industry a "fair shake." A few industry interviewees strongly asserted their view that the Commission was not dominated by or a tool of the industry.

It is also significant that several Commission staffers perceived themselves as acting in a "service role" to the industry. Legislative staff interested in the Commission's work also viewed it in that way, as did insurance representatives, a group interested in costs but only indirectly affected by the Commission's work. No interviewees described industry influence as minimal or lacking. A sample of the views expressed by different groups interviewed is presented in App. D.

Cooperative Versus Adversarial Interaction

A regulated industry may interact with a regulatory body in a number of ways. Relationships might be primarily *adversarial*. In the extreme case, the industry feels its basic interests are threatened. Consequently, relations between industry and the regulator are marked by conflict, lack of industry participation in decisionmaking, heavy reliance by the regulator on imposition of formal sanctions (i.e., use of the legal process and punitive means, such as fines, to enforce

[4] *San Rafael Independent Journal*, Monday, October 4, 1976, statement by Ms. Elizabeth Rowen.

compliance with "directives" or settle disputes), and resort to the courts by the affected industry to resolve otherwise irreconcilable differences. A primarily adversarial relationship connotes limited industry influence in decisionmaking.

Relationships can also be primarily *cooperative*. In the extreme case, basic industry interests usually are not threatened, industry participates in decisionmaking, and resolution of disputes does not rely on use of formal sanctions. A primarily cooperative relationship connotes an appreciable degree of industry influence.

A mixture of the two kinds of relationships is to be expected, with a generally adversarial agency sometimes cooperating with an industry, and a generally cooperative agency sometimes acting counter to industry interests.

Most interviewees perceived extreme cooperation between the Commission and health providers, particularly hospitals, and an adversarial mode between the Commission and the DOH. *None* of the interviewees perceived the relationship between the Commission and the hospital industry as adversarial--an indication that industry wielded considerable influence.

A number of interviewees perceived the Brown administration as more suspicious and antagonistic toward health providers than was the Reagan administration. According to a legislative staffer, the primary concern of Earl Brian, the Reagan administration Health and Welfare Secretary,

> . . . was how to reduce the State Medi-Cal budget and he sought regulatory controls over hospitals to control costs. He was, however, ready, willing and able to negotiate with the hospital industry. He did not appear to view them antagonistically . . . Brown people are antagonistic toward the industry. The Administration has placed avid consumer advocates in positions of high responsibility. Many of them feel that profits should not be made in health care and are adverse to private hospitals. This Administration seems to be characterized by a concern for the poor, a desire to control costs and an antagonism toward providers.[5]

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[5]Interview with legislative staff.

The Little Hoover Commission explored the relationship between private health providers and the DOH in the early days of the Brown administration and reported that private sector leaders were unanimous in criticizing

> . . . the adversary nature of their relationship to the Department, which is marked by a contentious expectation by department officials that the private providers are intent upon exploiting programs rather than making responsible contributions.[6]

According to a nursing home industry observer, both the Reagan and Brown administrations were interested in protecting the Medi-Cal budget. Under Reagan no emphasis was placed on quality of care. Under Brown there has been a greater willingness to do better on rates but there has also been a punitive approach toward the industry based on use of "strike forces" and legal sanctions. In general, hospital industry interviewees agreed that under Brown there has been a greater emphasis on "consumerism," and the long-term care industry has been used as a "whipping boy."

Several DOH officials who were interviewed found the Reagan administration more cooperative with the industry, and the Brown administration more adversarial. Also, cost containment was not an issue after federal price controls were instituted, but price controls had been lifted when Brown took over and he was forced to take action to control the Medi-Cal budget.

Important potential public benefits and risks are associated with cooperative as opposed to adversarial relationships. These relate to the objectives of regulation and to the economic and political stakes in the regulatory process. It can be argued that the "cooperative" mode has greater advantages when regulatory objectives

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[6]Commission on California State Government Organization and Economy, p. 40.

can be achieved best with industry support and industry bias imposes minimal risk (e.g., when the Commission has a narrow legal mandate).

The Commission's Executive Director has supported the cooperative approach. In his opinion,

> Hospitals are not "bad guys." . . . Those who suggest the Commission should not have worked closely with the industry should answer the following questions: What other ways would have been more successful? Could a better job have been done faster?[7]

On the other hand, if regulatory objectives require actions that an industry does not support or that may affect its economic and political interests (e.g., rate regulation), a more complex balancing of public and industry interests may be required--perhaps a more adversarial mode of interaction or at least an "arm's length" relationship.

On the whole, both the cooperative and adversarial relationships probably produce some negative effects. The extreme cooperative approach probably invites excessive industry influence, but since the Commission's powers were limited, the short-term effects of cooperation were probably less negative than they would have been if it were a rate regulatory body.

EFFECTS OF BIAS

If there was pro-industry bias in the health facility regulatory process, what were its effects on the Commission? Did socially undesirable outcomes result? Four major conclusions are discussed below.

1. Although some actions of the Commission were due to pro-industry regulatory bias, the results apparently were not socially undesirable, if only because the Commission's role was narrowly circumscribed and did not directly affect the industry's vital economic

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[7] Interview with Robert Murch, April 29, 1977.

interests. In fact the Commission produced the first statewide inventory of California hospital financial and statistical information based on a uniform accounting and reporting system, which most interviewees regarded as a good system.

2. The Commission was not a puppet of the hospital industry. It took positions at variance with those of the industry and at times was in conflict with it.

3. The industry achieved what we interpret as its primary objectives through the creation of the Commission and the containment of its powers. We view this apparent domination of the regulatory process as socially undesirable.

4. Although conceivably meritorious efforts to expand the Commission's authority were thwarted in the legislature largely because of industry opposition, it is premature to conclude that this defeat was socially detrimental. There is no convincing evidence as yet that either public-utility-like regulation in other fields, or health facility rate regulation tried elsewhere, have significantly contained costs.

Commission Actions Illustrating Bias

In 1975 and 1976 the Commission failed to support efforts to make it an all-public-member body and to remove the requirement that its Executive Director be a hospital administrator. These actions were taken after the Brown administration took office and several legislators said they would not support expanding the Commission unless its makeup were changed to eliminate direct industry representation on the Commission and its staff. The Commission Chairperson supported efforts to reform the Commission's membership, to remove the stigma of being considered "in the pocket of the industry."[8] Industry representatives voted to keep things the way they were.

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[8]See Commission Minutes of November 19 and December 17, 1975, and May 13, 1976.

Industry membership on a regulatory commission may have merit, but of course it invites bias. In the case of the California Commission, the *requirement* that industry be represented *and* that the Executive Director be a hospital administrator would seem to prejudice the Commission toward the industry. The Commission, as reconstituted after Governor Brown's 1977 appointments, supported legislation to eliminate the requirement that the Executive Director be a hospital administrator. This change was enacted, to become effective in January 1978.

One of the Commission's first major press releases, based on its analysis of hospital data collected, announced that industry was being "short-changed" by the government because the Medicare and Medi-Cal programs were not paying billed charges.[9] The release pointed out that California hospitals were paid $241 million less than they billed Medi-Cal, and that all other payors would have "saved $50 million" if all payors paid the same percentage of what they were billed. The release repeated an often-stated industry position without stressing that equal payment without overall cost containment would add to already spiraling Medicare and Medi-Cal costs. The Commission failed to require patient mix and intensity of service data, which would allow more precise and comparable measurement of hospital output, and failed to audit hospitals to assure the validity of hospital-reported data. Even after the DOH and legislative staff recommended the collection of data on patient mix and intensity of service, the Commission failed to mandate its collection in the face of opposition by the industry. The industry objected that it would saddle them with too heavy a data-collection responsibility. It was also argued that such data might be added later and was not required by law. Some Commission staff have favored audits, but the Executive Director has opposed them as needless on the grounds that internal checks indicate the data are accurate. The Commission seemed more

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[9]Commission Press Release, January 17, 1977.

attuned to not alienating the industry and less toward satisfying the needs of primary data users in the DOH and the legislature.

There was long delay in the release of Summary Reports to the public, and individuals requesting specific hospital reports were identified to the hospitals whose reports were requested. The Commission has not been aggressive in getting data out to potential users. Staff suggestions to speed up the reporting process were rejected by the Commission. The fact that it took five years for the Commission to release data--from its creation in 1972 until 1977--was justified by some Commissioners on the grounds that they did not want to present "misleading" information that could lead to inappropriate comparisons between hospitals. The requirement that persons requesting disclosure reports be personally identified is clearly a negative incentive for some to request the data, while the purpose of the law was to promote its public availability. The closer the Commission got to releasing data, the more sensitive industry became to its release and the slower the process appeared to go.

The Commission retracted requirements for disclosure of hospital administrators' salaries and the financial arrangements between hospital-based physicians and their hospitals. A reason given for eliminating salary disclosure was that it might drive salaries up. A more likely reason was opposition from administrators who did not want to be embarrassed by public release of their salaries and the possibility this might result in public pressure to reduce them. A reason given for backing off from disclosure of physicians' remuneration from hospitals was that, when this requirement was initially instituted, physicians began billing separately for their services and thus avoided the Disclosure Act and reduced hospitals' income. However, it is also clear that such disclosure would probably embarrass some physicians and hospitals because of lucrative contracts, some of which provide the physician a share of gross hospital revenues.

The Commission's economic stabilization program proposed in 1975 would not take effect until both federal and state providers agreed to pay "fair rates" (i.e., the same rates as third-party purchasers). Also, the proposal did not specify overall cost-containment guidelines and methods. In addition, providers were to make up two-thirds of the membership of both technical review boards that would be established to make recommendations to the Commission on rate regulation and Certificate of Need guidelines. It appears that these provisions would have resulted in a commitment to increased government costs, at least in the short term.[10]

The report of the Commission's January 1976 Task Force on Short and Long Range Objectives, proposing that a specific cost growth target be set for the hospital industry and that rate regulation be used to phase out unneeded facilities and services, was substantially modified after major opposition by provider groups. The Advisory Council, after soliciting the views of providers, recommended that the growth target be subject to further study, that all parties agree to pay equal rates in advance, and that hospital decertification not be part of budget and rate review. The Advisory Council recommendations were accepted by the Commission.

According to one Commission staffer, the nursing home accounting system may not result in comparability of costs between different facilities. It is too early to confirm or refute that opinion, because nursing homes have not yet begun filing reports; however, it appears that compromises made after nursing homes objected to the first-draft accounting guidelines may well result in noncomparable data. Those supporting the revised regulations accepted by the industry suggest that the system first proposed was unworkable and unnecessarily burdensome, and would have required a system modeled after the one for hospitals. They argue that nursing homes are

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[10] CHA did not support this proposal in its legislative form (SB 1107). After federal price controls were lifted, their enthusiasm for any control system diminished.

neither as complex nor as sophisticated as hospitals and that the revisions produced the best nursing home accounting system in the nation.

Social Desirability of Outcomes

These examples suggesting pro-industry bias are significant but must be measured against positive outputs of the Commission. It produced a uniform accounting and reporting system and California's first published inventory of hospital financial and statistical information based on that system. Commission members viewed the development of a hospital accounting and reporting system *with the cooperation of the hospital industry* as their most important accomplishment. Most persons interviewed pronounced the system a good one, although some would have liked to see more extensive data collected faster.[11] They included representatives of the DOH as well as of insurance companies and providers. Moreover, the accounting system is being used as a model by the Social Security Administration.

Thus, even though a number of Commission actions suggest pro-industry bias, its role was narrow and circumscribed and, despite some criticism, there appears to be general agreement that it did a good job on its primary task, the development of a uniform accounting and reporting system for hospitals. Also, it is questionable whether such a system could have been set up without the cooperation of the industry. While it can be argued that a less biased Commission could have produced a "better" system and recommendations more favorable to the public interest, it would be difficult to point to Commission actions that have produced socially undesirable results as yet, if only because its authority was so limited.

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[11] We have not independently evaluated the Commission's accounting and reporting system. Also, it would be premature to assess the cost-containment effect of public disclosure, since Commission data have only recently been made available.

Perhaps more important, however, the Commission was initiated and designed by the hospital industry to achieve industry objectives. As we interpret them, the industry's primary objectives were to get a uniform accounting, reporting, and disclosure system set up by a "friendly" or at least not unfriendly Commission, to prevent unacceptable rate regulation, "buy time" while it sought to determine future policies toward government regulation, buttress the industry case for higher rates from the government, and keep future rate regulation away from the state's major purchaser of care, the DOH. All these objectives were achieved. In our view, the apparent control of the regulatory process to achieve industry objectives is socially undesirable per se.

In large measure, the exercise of political muscle in the legislature by health provider groups prevented the Commission from growing into a powerful agency that might have had major effects on their economic interests. Substantially aided and abetted by what many key legislators viewed as the DOH's ineptitude, provider groups also helped to prevent the Commission from being eliminated and the DOH from expanding its rate regulatory power. Moreover, even should the Health Facilities Disclosure Act be successfully implemented, this by itself is not likely to have any serious direct effects on the hospital industry as compared, for example, with other proposed--and defeated--regulatory measures such as rate limits.

An important question, however, is whether the failure of the legislature to create either a public-utility-like Commission for health facilities or a rate regulatory body was a socially undesirable outcome because it prevented the institution of potentially effective cost containment. (We assume for the sake of argument that facility cost containment is socially desirable.) According to Noll, Havighurst, and Schlenker, public utility regulation fails to contain costs, promotes inefficiency, and retards innovation.[12] Also, political economic

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[12]See R. G. Noll, op. cit., Clark C. Havighurst, *Public Utility Regulation for Hospitals*, August 1973, Reprint No. 17, and R. E. Schlenker, *Public Utility Regulation of the Health Care Delivery System: Lessons From Other Regulated Industries*, Interstudy, April 1973.

theory suggests that even when a regulatory body is established it is likely, in the long run, to be biased toward the regulated industry--in this case, the hospital industry. Moreover, there is either incomplete evidence or controversy about the effectiveness of rate regulatory approaches tried thus far. One evaluator of rate-setting programs pointed out:

> State and regional experience during the 1970s indicated that in and of itself, hospital rate setting is by no means the way to salvation. Federal policymakers were wise not to have prematurely rushed into this plausible sounding route to cost containment. Setting rates for thousands of hospitals of diverse character at the point that will induce greater "efficiency" and that will at the same time protect the legitimate concerns of third party payors, providers, patients and the bill-paying public is easier legislated than accomplished. The methodology for implementing a task of this delicacy is still at the primitive stage. Worse, well-intentioned mistakes in designing either the structure or the processes of rate setting may be counterproductive, quite possibly they may actually stimulate increases in overall hospital care expenditures.[13]

Clifton R. Gaus, Director of the SSA's Division of Health Insurance Studies, cautioned that the results of a HEW-sponsored evaluation of seven prospective payment systems showed they did not pass "rigorous statistical tests." He concluded that those programs were "moderately successful" in lessening the pace of inflation in the neighborhood of 1 to 3 percent per year, but were "no panacea for bringing hospital costs in line with inflation in other economic sectors."[14]

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[13]Katherine G. Bauer, "Hospital Rate Setting--This Way to Salvation?" prepared in January 1976 as a chapter of the forthcoming book *Hospital Cost Containment*, Michael Zubkoff and Ira E. Raskin (eds.), pp. 53-54, to be published under auspices of the Milbank Fund.

[14]Quoted in John K. Inglehart, "Health Report," *National Journal*, December 25, 1976, p. 1824.

In states where rate regulation is mandatory and the inflation rate is slightly less than the national average (e.g., Maryland and Connecticut), it is difficult to ascribe the lower rate to the existence of rate regulation per se as opposed to other factors.

Proponents of rate regulation suggest that even a small percentage savings would be significant in a state like California (e.g., a one-percent saving equals more than $50 million a year); however, the overall benefit to the state in relation to its costs has yet to be demonstrated.[15]

RESPONSIBILITY FOR BIAS

If there was pro-industry bias, then who bears responsibility for it? In analyzing this question, it is important to distinguish between bias in the health facility regulatory process and bias on the part of the Commission itself. We draw distinctions among the responsibilities of (1) the legislature, which charted the Commission's statutory course; (2) the administration in power, which conditioned how this course would be followed by the appointment process and political support or opposition for the Commission; and (3) the Commission itself in implementing its regulatory mandates.

The legislature created an agency with limited powers, essentially ratifying the prior decisions of the industry to support limited regulation. Subsequent legislative attempts either to expand or contract the Commission's powers were unsuccessful despite their support by some key legislators and both gubernatorial administration, largely because of the legislative influence of health provider groups. Thus, bias in the health facility regulatory process is largely the product of actions of the legislature, which first established a Commission with limited powers and open to industry influence and, second, then

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[15] We do not argue here that the state should not enact rate regulatory legislation on these grounds. One of the values of federalism is that it permits states to experiment on a regional basis. California conceivably could design an effective program which then might be a model for the nation. We conclude that since the effectiveness of such regulation has not yet been proved, failure to enact such a program cannot be considered socially undesirable.

failed to take actions to change or expand the Commission's role that the industry opposed. However, the legislature did act in 1974 to give the Commission a public-member majority, but it took Governor Brown almost two years to make the appointments and develop policy in the field of health facility regulation. The primary result of this failure to act was that, between 1975 and 1977, industry influence on the Commission was preserved (since public members were left in the minority) and the Commission (without any change in its makeup), faced first with uncertain support and then with outright opposition from the administration in power, was unable to substantially curtail it.

During the Reagan administration, hospitals were consulted on Commission appointments and generally had close relationships with Dr. Earl Brian, Governor Reagan's Health and Welfare Secretary. Consumer advocacy groups had no input to the appointment process. Governor Brown's 1977 appointees were very different from those of his predecessor. Industry was not consulted on appointments, and it appears that the new appointees have changed the posture of the Commission and significantly curtailed industry influence on it.

The pro-industry bias of the Commission during its early years was predictable, given its initial narrow charter and the primary influences on it. The Commission implemented its limited charge with industry support and cooperation. Commission and industry interests generally coincided in the development of an accounting and reporting system. (However, as public disclosure came closer, industry and Commission interests began to conflict, since the Commission would gain stature and attention by public release of disclosure data that might be embarrassing to hospitals.) The Commission proposed actions expanding its own regulatory role that the industry either failed to support (or opposed) and the legislature failed to enact.

Responsibility for pro-industry bias probably rests least with the Commission itself and most with the legislature and the two gubernatorial administrations during which it functioned. The

Commission's course was charted and circumscribed by the legislature, for the most part, in response to industry pressures and by Governors Reagan and Brown, who made appointments to it and chose to support or oppose it. Industry influence was curtailed by Governor Brown's recent appointments, as it was preserved by his initial failure to make them in 1975 and 1976.

CONCLUSION

Overall, we conclude that the health facility regulatory process involving the Commission as a key participant was biased toward the CHA and other allied hospital and provider interests. Moreover, the Commission itself, until recent appointments by Governor Brown, exhibited pro-industry bias, particularly during its first several years. Also, its freedom of action was kept confined within narrow bounds, owing largely to the influence of provider groups, particularly the CHA. The Commission's implementation of its statutory requirements was guided by CHA. Efforts to expand or contract its authority or to increase the number of public members on it were defeated when opposed by provider groups that exercised effective lobbying power in the legislature.

In general, it seems that pro-industry bias was preordained by the structure of the Commission, initial appointments to it by the Reagan administration, and the regulatory environment in which it operated. The Disclosure Act, itself initiated by hospitals, set the stage for pro-industry bias by assuring industry membership and participation in decisionmaking; developmental work by CHA staff and able representation of hospital interests before the Commission did the rest. The industry had a vital stake in the Commission and it seemed that during most of its life the interests of the Commission were well served by working with the industry. Few countervailing pressures came from consumers or other groups to counterbalance industry influence, until Governor Brown made appointments to the Commission in 1977.

Although we view industry control of the regulatory process as socially undesirable, it seems not to have produced socially undesirable outcomes thus far. The Commission has created the first California inventory of hospital financial and statistical information, based on an accounting and reporting system that is generally well regarded. The Commission has not been a puppet of the industry; it has taken positions that industry sometimes opposed. The failure of the state to enact meaningful regulatory legislation is a testament to the political influence of provider groups in the legislature, even though there is no assurance that such legislation would result in significant cost containment. It is also possible that such legislation might engender negative side-effects whether or not costs were lowered. The responsibility for pro-industry bias probably rests less with the Commission than with the legislature that initially created it (and kept it circumscribed largely in response to industry pressures) and the two gubernatorial administrations under which it functioned. Governor Brown, for example, delayed for two years in appointing Commissioners after legislation effective in 1975 established a public-member majority.

With Governor Brown's appointment of a number of consumer advocates as Commissioners in 1977, the Commission has entered a new phase. The new Commission has already proved more aggressive than its predecessor, but its powers are still constrained and its direct influence on facility costs--like that of its predecessor--is limited to collection and release of data, analysis, and recommendations.

Chapter 4
HISTORY OF THE HOSPITAL DISCLOSURE ACT[1]

The Hospital Disclosure Act of 1971 creating the Commission was the industry's response to growing hospital costs and political pressures to do something about them. This chapter describes the origins of the Act, the pressures that led the California Hospital Association (CHA) to develop and sponsor it, and the CHA's objective. It examines the issues the CHA considered in developing its proposal, legislative action on the proposal, and the positions of interested organizations and compromises between them.

EARLY HISTORY

The seeds of the Hospital Disclosure Act were sown when rapid hospital expansion during the 1950s prompted the Governor's Committee on Medical Aid and Health (the "Egeberg Committee") to conclude: "California hospitals have developed in the past ten years in a haphazard manner which is not in the best public interest. Projecting California's 1950-1960 building patterns to 1975 would, in the Committee's opinion, be disastrous."[2]

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[1]To document the origins of 1971 legislation creating the California Hospital Commission, we interviewed 27 people who were involved in developing the legislation and in the executive and legislative response to it. Of the 27 persons interviewed, 10 were from the hospital industry, 2 from medicine, 6 were associated with the legislature, and 6 were in the executive branch with either the Governor's Office, Health and Welfare Agency, Department of Public Health, Department of Health Care Services or Department of Finance, 2 were from labor and 1 with a federal agency. We also examined hospital industry literature discussing the history of the Act.

[2]*Health Care for California: Report of the Governor's Committee on Medical Aid and Health*, December 1960, p. 40. The Committee was headed by Roger Egeberg, who later served as Assistant HEW Secretary for Health in the Nixon administration. The report proposed a goal of 7.5 beds per 1000 population. According to the American Hospital Association, hospital beds per 1000 population in California in 1975 were 3.92.

The Committee found that lack of organized planning had resulted in poor geographic distribution of services and expensive duplication. They projected that proper facility planning would save $650 million without adversely affecting care. The December 1960 report called for the establishment of a planning system under which the Department of Public Health would develop regional plans with the advice of regional councils composed of provider and consumer interests. Public hearings would be held by the Council on all plans in "substantial conflict" with the regional plan, at which time "verified information on the need, feasibility and character of the project" would be required.[3]

During the deliberations of this group, one of its advisory panels suggested that all hospitals disclose information about their operations in a manner similar to that required of corporations registered with the Securities Exchange Commission; not until 1969, however, was legislation finally enacted establishing areawide planning agencies with authority to review proposals to add hospital beds.[4]

PRESSURES FOR CHANGE

Our interviewees mentioned several reasons for the CHA's sponsoring the Hospital Disclosure Act:

- Rising hospital costs and the inability of hospitals either to control them or justify their charges convincingly;

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[3]Ibid. Two Commission members (J. E. Smits and A. B. Halverson) were associated with this Committee, as were the CHA Counsel, James Ludlam, and the long-time CHA liaison with the Commission, Gordon Cumming, then chief of the Bureau of Hospitals in the Department of Public Health.

[4]According to CHA Counsel James Ludlam, this legislation (SB 212) was not enthusiastically received by hospitals, although Southern California hospitals supported it. According to hospital industry interviewees, this legislation was scuttled after opposition by doctors, Northern California hospitals, and Kaiser. Federal legislation in 1966 (PL 89-749) authorized creation of regional planning agencies.

- o Political pressures for consumers and government officials to "do something" about rising costs and charges;
- o "Unfair" rates paid to providers and "arbitrary" payment cutbacks in public programs (i.e., Medicare and Medi-Cal);
- o Industry responses to these pressures.

Rising Costs

Between 1960 and 1970 California hospital expenses increased from about a half billion to about two billion dollars, a fourfold increase; per capita expenses rose more than 200 percent.[5] Hospitals were concerned about their "tarnished public image"; as CHA president David Odell said to a legislative committee in 1970:

> Credibility of our hospital costs with public officials and with patients . . . is probably at its lowest point . . . The public and public officials assume that hospitals somehow can get along without being paid, that either philanthropy or Robin Hood or somebody will come along and pay our costs.[6]

One member of the Commission's Advisory Council said that hospitals believed they had to respond to criticisms and provide evidence they were not "ripping people off."

A major stimulus to CHA action was the alleged inability of hospitals to control costs generated primarily by physicians. A consultant to CHA commented that many hospital administrators felt "whipsawed" by physicians to provide more and better equipment and services to keep their medical staffs happy. Demand for hospital services was intensified by new medical technology, new treatment methods, and broader coverage for health care costs under both labor-management agreements and government programs.[7]

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[5] *Hospital Fact Book*, Table 3, p. 4.

[6] Transcript of Interim Hearing on Hospital Rates by the Senate Committee on Health and Welfare Subcommittee on Hospital Rates, December 9, 1970, p.5.

[7] Interview with Dr. Fred Morrissey, September 24, 1976.

Some observers have blamed federal adoption of retrospective "reasonable cost" reimbursement for the Medicare and Medi-Cal programs as a major stimulus for cost growth. With government and other third parties guaranteeing to pay their costs, providers had no incentives to produce efficiently.

Political Pressure

Einar Mohn, International Director, Western Conference of the Teamsters, and Chairman of the California Council for Health Plan Alternatives (CCHPA), told the 1968 CHA Annual Meeting that unions were tired of seeing inflationary cost increases eat away large gains in employee health benefits. He said a primary goal of the CCHPA was to place maximum pressure on providers to use resources efficiently by exerting the influence of labor union members as consumers of health care. He also recommended that hospitals be fully accountable to the public.[8]

During the late 1960s the CCHPA held meetings with insurance providers, hospitals, and medicine to explore cost containment approaches, but according to one CCHPA observer, they ended up blaming each other for cost increases and disclaiming responsibility for control.

The CCHPA attempted to audit several hospitals in the San Francisco Bay Area and became interested in pushing for disclosure when they were not permitted to do so.

SB 1359, introduced by Democratic Senator Anthony Beilenson in 1970 at the request of the CCHPA, would have restructured the State Health Planning Council by expanding the role of consumers. It would have empowered the reorganized council to regulate hospital rates and require facilities to disclose their costs, sources of income, and utilization. Enactment of the legislation was not anticipated since the CHA and other provider groups strongly opposed it. A primary

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[8] *A Collection of Speeches Presented at the California Hospital Association Annual Meeting, October 21 and 22, 1968*, published by California Hospital Association.

purpose was to pressure the hospital industry to respond to consumer complaints about rising costs. To keep the pressure on, Senator Beilenson, who was Chairman of the Senate Health and Welfare Committee, tentatively scheduled hearings on hospital rate regulation by his Subcommittee on Hospital Rates for mid-November 1970. CHA thereupon agreed to cooperate with Senator Beilenson in examining cost control alternatives, and he agreed not to push the bill.[9]

Republicans in the legislature also exerted pressure on hospitals. John Veneman, former Chairman of the Assembly Health and Welfare Committee and coauthor of the State's 1976 Medicaid Law, told the 1968 CHA Annual Meeting that hospitals "have the obligation to encourage the effective operation of these [public] programs or pay the price of increased regulation."[10]

Interviewed officials in both the Department of Health Care Services and the Department of Finance criticized data presented by hospitals to support their requests for higher rates. These agencies favored improvements in hospital data collection and reporting that would provide a sound basis for their rate-setting for governmental programs. Blue Cross and other insurers interviewed were also interested in the development of better systems to monitor costs.

"Unfair" Rates

Both federal and state government purchasers responded to cost pressures by instituting cutbacks in government reimbursement--an action that, according to one industry source, left the industry at the mercy of government, a monopsonistic purchaser, which gave only secondary consideration to financial solvency of hospitals.[11]

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[9]Beilenson letter to CCHPA President Einar Mohn, August 4, 1970.

[10]*A Collection of Speeches*, pp. 17-22. Mr. Veneman's remarks were delivered by the author, who, as a legislative consultant, attended the Santa Barbara meeting on his behalf.

[11]Speech by Henry Zaretsky, at a conference entitled "Input 73," sponsored by CHA, Los Angeles, Calif., June 9, 1973.

Medi-Cal changes imposed by the State Department of Health Care Services that established a system of prior authorization for non-emergency hospital admissions, and a schedule of maximum allowances for physicians, stimulated industry concern about future cutbacks, according to hospital interviewees. Lower reimbursments from government programs meant higher charges to nonpublic patients to meet costs.

Industry Responses

Some industry leaders believed that increased government regulation of hospitals' financial affairs was inevitable because of expansion of government purchasing through Medicare and Medi-Cal and the likely prospect of National Health Insurance. As a CHA spokesman pointed out:

> Government is the biggest purchaser [of health care]. Money talks. The customer is always right. Other similar slogans and statements can be made to support the inevitability that as the government payment system goes so goes the entire payment system. And government, which must pay 40 percent of the health care cost, cannot tolerate a fragmented payment system with its looseness and lack of control . . . If the name of the game is "predictability and control" for government, it is obvious government will require prospective rate setting.[12]

Industry leaders urged the CHA to take the initiative so that an unacceptable form of rate regulation by the DOH or a federal agency would not be thrust upon them. The author of the Disclosure Act said the CHA initiated his bill to forestall arbitrary regulation. "They wanted to establish a group separate from the Health Department to perform these tasks since Health was a major purchaser of care and they felt that rate setting by that Department would constitute a conflict of interest."[13]

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[12]Gordon Cumming, "Why Government Will Require Prospective Rate Setting," *UHA Reporter*, Summer 1972, p. 6.

[13]Interview with former Senator Stephen Teale, March 22, 1977.

Meanwhile, the American Hospital Association (AHA) was examining alternative forms of regulation that might be acceptable to the industry. AHA leadership was credited by some observers with stimulating CHA to participate in the design of a state regulatory program. AHA in 1970 approved a "Statement of Financial Requirements of Health Care Institutions." Among other things, the statement concluded that "methods of payment based on prospectively determined rates have very real opportunities for improvement in meeting the objectives of public accountability, predictability, and preservation of institutional autonomy."[14]

Also in 1970, the AHA established an Advisory Panel on Public Utility Regulation. The views of this panel were later reflected in CHA's 1972 guidelines, which recommended prospective payment and the establishment of independent state commissions that would review and approve rates of individual institutions.[15]

The CHA was also influenced by events in other states. Rate regulation authority was given to the Health Commissioner in New York without major participation of hospitals. In New Jersey efforts were under way to develop a prospective ratemaking system. Indiana for many years has had a voluntary system administered through its hospital association. Pennsylvania, Illinois, and other states were considering rate review methods. The National Health Insurance Association, along with AHA, called for action at the state level to slow hospital cost growth.[16] As a result, the CHA was motivated to prevent the development of programs such as the one developed in New York without hospital participation.

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[14]AHA *Policy on the Implementation of the Statement of Financial Requirements of Health Care Institutions and Services*, December 29, 1970.

[15]See CHA recommendation for 1973 program adopted January 11, 1975.

[16]Interviews with CHA staff and interview with Lou Orsini National Health Insurance Association of America, May 9, 1977. See AHA *Policy Statement on Financial Requirements*.

Some people in the industry believed that public utility regulation of hospitals might be a good thing for both the industry and the public. In 1968 the outgoing president of the CHA, Gordon Cumming, startled some of its members by suggesting at its annual meeting that:

> We must acknowledge hospitals have a public nature, regardless of their ownership. *If we are to be reimbursed adequately* for effective services, the public will insist on disclosure and restraint of hospital costs. *I think this can best be accomplished in the public interest and in the preservation of our voluntary system by creating a State Commission to regulate hospital building, services and charges* . . . I do not think this is a radical suggestion. It is going to happen anyway. We will have a stronger voice if we have initiated the idea. I hope we can take the leadership in establishing a hospital commission but I know there are some here who will disagree.[17]

Supporters of public utility regulation believed it would not hurt hospitals, and would lend them financial stability. In their view, such a system would establish equitable charges and controls that the industry could live with in place of unpredictable actions by government purchasers and ineffective piecemeal planning. Some envisioned that recently created local health facility planning bodies would be subsumed under a public utility regulatory agency.[18] Public utility regulation had few adherents when CHA began debating its options in 1970, but the idea gathered support during the next few years as the government intervened further in hospital affairs.

The CHA also took action because of its past inability to collect good data from its members on a voluntary basis, and the attractiveness of disclosure to those who opposed strong government regulation. The

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[17] *A Collection of Speeches.*

[18] In 1969 the state enacted a CHA-sponsored Certificate of Need Law (AB 1340, Duffy) giving local authorities powers to control facility expansion.

industry had tried unsuccessfully for years to collect cost data that could be used to justify reimbursement requests and might promote efficiency in a less painful way than outright rate regulation.

CHA ACTION

After reviewing programs in other states and other experimental efforts, the CHA Board of Trustees concluded that "prospective payment was indeed inevitable, is necessary and inevitably involves some form of regulatory surveillance," that some regulatory body would have to establish the legitimacy of services and rates, and that CHA should participate in the design and implementation of such a regulatory system in California.[19]

The CHA membership appeared to be of two minds about the type of regulation they should support. Some favored "private" regulation similar to the Indiana system, which some described as the "baseball commissioner" approach. Others believed that a government agency was necessary, would be more acceptable to the public, and was inevitable because of increasing public financing of health care.

The CHA leadership became convinced that Indiana's voluntary approach would not work in California. All Indiana hospitals are nonprofit; and because Blue Cross provides most of the health insurance coverage, other companies follow its lead in accepting a rate. California has many proprietary hospitals and a diversified insurance market.

With some form of financial regulation clearly in the offing, however, the CHA sought advice from an expert in the field. Early in 1970 it retained Dr. Fred Morrissey as a consultant. Dr. Morrissey was a professor of business administration at the University of California, and a former member of the CPUC. Dr. Morrissey helped the industry define its problems and identify alternative solutions to them.

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[19] Thomas E. Tonkin, "Proposal for Public Regulation of Hospital Financial Affairs," Part 1, "Introduction: The Road to Policy," *Hospital Forum*, Vol. 13, No. 8, November 1970, p. 3.

Morrissey Study

Dr. Morrissey studied the hospital industry, analyzed fiscal trends, and consulted with hospital administrators, physicians, consumers, and industry groups, to whom he explained the elements of public utility regulation as practiced by the California Public Utilities Commission (CPUC) and how such regulation would affect the hospital industry.

During his work with CHA, several approaches to control costs were considered:

1. *Financial data collection and public disclosure* to promote public confidence, illuminate the forces behind cost increases, and improve hospital efficiency.

2. *Control over capital expansion* to force consolidation and prevent further construction of inefficient or unnecessary facilities.

3. *Rate approval or rate setting* to control cost growth.

He also brought CHA in touch with the problems and regulatory structures of CPUC regulated industries, particularly the trucking industry, where extensive cost determination was used in setting minimum rates for a particular service. He believed such regulation might eventually be applied to hospitals.

After several months of study, Dr. Morrissey concluded that the hospitals "could qualify readily as a public utility [but] to do so would subject hospitals to regulation by the California Public Utilities Commission of a type and degree that I suspect the industry is not prepared for, and with which they would be very unhappy. Moreover, I suspect it is not necessary . . . or appropriate at this stage."

He also concluded that:

> The industry is also in need of self-scrutiny of its productivity, its efficiency, its cost determination and justification procedures, and that some sort of independent review agency should be established with representatives of the public in addition to hospital and medical representatives providing for hospital financial disclosure. In the absence of some such

> agency with independent review powers, credibility in the face of escalating rates and costs is going to be difficult to achieve.[20]

He regarded a system of cost determination and cost comparison as a prerequisite to any workable form of rate regulation. He also considered the hospital industry sufficiently different from those regulated by the CPUC to warrant creating a separate body to collect the needed cost data.[21]

After presenting his initial conclusions to the CHA Executive Committee in May 1970, Dr. Morrissey was asked to direct the development of a plan for *financial disclosure* to be applicable to all short-term-care hospitals. While stopping short of rate approval, the plan he was asked by CHA to develop was to assume that prospective rate-setting would be compulsory *ultimately* and that rate approval would follow *eventually*. The major initial goal of the plan would be to test the effect of financial disclosure on hospital rates.

Dr. Morrissey submitted the following recommendations to the CHA Board of Trustees in September 1970:

- *A system of financial accounting and disclosure* based on conventional accounting systems; (1) a yearly "balance sheet"; (2) *a statement of income and expenses* for the same period, and (3) *a statement of source and application of funds* showing that sources were used for specific purposes.
- *Disclosure of statistics describing utilization* of specific equipment and services.
- *Adoption of a cost accounting system* to relate rates to costs.

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[20] *Hospital Forum*, pp. 7,8.

[21] Interview with Dr. Morrissey, September 24, 1976.

- o *Creation of an agency independent of other agencies* of government and the industry, financed either by industry assessment or general funds.

He also went further than consideration of disclosure alone because of his belief in the likely future adoption of (1) *prospective rate-making* and (2) some form of *franchising* or review process for new facilities. He therefore suggested the preparation of a yearly forecast of revenues and expenses and a cash budget describing the flow of funds, along with planning data on future service and facility requirements. These data would be necessary to support prospective rates and justify the need for additional facilities.

He supported disclosure

> . . . not merely to head off regulation by some other governmental body. Rather regulation should be considered also as a vehicle for improving hospital management practices, for providing means for cost control and cost comparisons, for demonstrating to the public and the critics that the health care industry is efficient and that it is willing to put its own house in order and not wait for external factors to force changes on it.[22]

Such disclosure also would present cost and utilization data to counteract unilateral decisions by large buyers to set prices without regard to equity.

A CHA official summed up Dr. Morrissey's contribution by saying that

> He made the membership understand what a public utility was, what regulation meant, what the requirements for regulation were and that, as in the case of the trucking industry, regulation might not be adverse to industry interests . . . . Gradually, he began to tailor his suggestions to what the industry would be ready for and accept.[23]

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[22]Memo to CHA Board of Trustees from Dr. Morrissey, undated.

[23]Interview with former CHA Government Relations Director, September 21, 1976.

The CHA Position

Having explored issues related to prospective reimbursement, rate regulation, and disclosure, the CHA was then faced with choosing a policy direction. Within CHA the main questions were:

- *Should CHA recommend prospective reimbursement or rate-making and propose a system to implement that regulation?*
- *Should CHA recommend legislation requiring disclosure and propose a measure to implement that recommendation?*

At its September 9, 1970 meeting, the Board of Trustees decided that the answer was "yes" to the second question, "no" to the first.

Morrissey's recommendations on disclosure of historical financial data became CHA policy, but the industry was unwilling to support his suggestions for the preparation of revenue forecasts and budgets to support prospective rate-making.

A critical aspect of the Trustees' position was their conviction that disclosure should be administered by "an independent agency," separate from the state bureaucracy concerned with purchase of care (i.e., DOH and Department of Finance). Before the CHA's annual meeting in October, the CHA leadership and staff strove to gain support for its position. As one CHA staffer put it, "We had to lobby like hell to get the policy position favoring disclosure accepted by the industry."

The United Hospital Association (UHA), representing investor-owned facilities, supported the CHA position; but a number of administrators in the CHA, some of them from investor-owned hospitals, were not enamoured with disclosure and felt the industry was helping to dig its own grave by supporting government regulations. Although it supported the CHA position, Kaiser was concerned about how the accounting and reporting requirements would be applied to their unique situation. Opponents went along with the Association position reluctantly, partially on the grounds that CHA support for disclosure might help to forestall stronger rate regulatory legislation.

LEGISLATIVE ACTION

The first public statement of CHA's position was presented at the December 9, 1970 Hearing of the Senate Health and Welfare Committee's Subcommittee on Hospital Rates.

The committee's interest was in stemming the tide of inflationary hospital rate increases and easing the consequent pressures on the Medi-Cal program. At the hearing, Morrissey argued that no regulatory agency, including one empowered to regulate rates, could decrease or even stabilize hospital rates; at best, it might slow the trend. He pointed out that cost increases were largely due to new technology and to wage increases granted to lower-paid workers. However, he also pointed out examples of inefficient use that occurred when too many individual hospitals added new equipment or new "prestige" units that a number of hospitals could have shared. A disclosure law would make hospitals and doctors alike more cost-conscious and stimulate improved management, and the resulting data would be available not only to an independent agency for study but also to large buyers, including government agencies. Morrissey also noted that with prospective rate-making, which he expected to occur, the agency created by this proposal would be able to review the proposed rates and the costs cited to justify them. In the future, the agency might also be empowered to certify new facilities or expansion of existing ones. His major argument, however, was that a rational basis for cost determination and rate review did not then exist and it would be premature to provide for such review until more was known about costs through financial disclosure.[24]

The spokesman for the CCHPA supported the creation of an independent Commission to collect and disclose cost data but said it would be "meaningless" if not accompanied by broader regulatory control, including prospective budgeting and rate-setting. He suggested regulation was necessary because consumers could not

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[24]Ibid., pp. 20-55.

influence costs, the reasons being that the physician determines the care needed, and the consumer is unable to shop on the basis of price alone. He was also concerned that the Commission proposed by the CHA would be dominated by the hospital industry and would not be responsive enough to the public and consumers.[25]

After the hearing, Senator Beilenson commented that the proposed legislation should have clear sailing in the legislature since it originated from the hospitals themselves. He also noted that it was "very likely" the CHA bill was introduced to head off tighter rate regulation by the state. Assemblyman Duffy, Chairman of the Assembly Health and Welfare Committee, said, "I don't think there's any question that eventually you're going to go to rate regulation."[26]

Considerations in Drafting the Disclosure Law

After the CHA adopted its policy, it instructed its legal staff to draft legislation to be sponsored by the CHA: A number of issues remained to be resolved concerning the structure, powers, and duties of the Commission. Following is a brief discussion of the issues and how they were resolved before legislation was introduced.

Public Versus Industry Representation. A major issue facing the industry was how to design the membership of the Commission so as to promote maxmimum industry involvement in its decisionmaking but still win acceptance by consumers and legislators. The compromise solution provided for three public members, three members from health industry providers (a hospital financial officer, a hospital chief executive officer, and a physician), and one from health insurance. The members would be appointed by the Governor for four-year overlapping terms. The Chairman would be elected by the members but was to be a "representative of the general public." The Commission's executive

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[25]Statement by Thomas Moore, CCHPA Executive Director, prepared for December 9, 1970 Hearing of Senate Health and Welfare Subcommittee on Hospital Rates.

[26]*Sacramento Bee*, December 10, 1970, p. 1.

secretary, however, was to have at least five years experience in hospital administration. To assist the Commission, a 10-member Advisory Council appointed by the Commission was to be established, including five hospital representatives "broadly representative of the interests of investor-owned, county, university, district and nonprofit hospitals," three "consumers," including a labor union representative, and one appointee each of the Director of Health and Mental Hygiene. The industry representatives were to be selected from nominees submitted by qualified organizations.

The advisory committee was strongly advocated by representatives of proprietary hospitals. It was seen as an important vehicle for industry input and was given responsibility to make recommendations regarding Commission rules and regulations and veto power over any special studies.

Service and Salary. Commission members could be full-time or part-time and paid or nonpaid. It was determined that more qualified people, probably more attuned to industry concerns, would be available on a part-time basis, and should be paid per diem for time spent on Commission business and for other expenses. The Advisory Council members would not be paid but would be reimbursed for expenses. As introduced, the bill did not specify the salary of the executive secretary, although an earlier version provided that the chairman of the Commission be its full-time executive at a salary of $35,000.

Accommodation for Different Types of Hospitals. Representatives of the Kaiser Foundation Hospitals and of some county hospitals were concerned that the CHA system was designed for hospitals operating on a fee-for-service basis and would require them to install a costly accounting system. To accommodate to this concern, one provision was inserted allowing modifications in approved accounting systems, and a second that permitted any hospital to file cost and statistical information required under the Medicare program in place of the data required by the Commission. This was to assure that hospitals, particularly smaller ones that had initial difficulty in compiling these reports, would not be held in violation of the law.

Industry Versus Public Financing. Although some within the industry favored public financing, it was decided that the Commission would be funded by the industry to assure stable funding not as easily subject to shifts in budgeting priorities. Funds from industry assessments would be appropriated by the legislature to support the Commission. Also, there was some concern that the Department of Finance might oppose a General Fund appropriation because it could increase costs to the state.

Legislative Response

The CHA-sponsored legislation was introduced by Senator Stephen Teale (D-West Point) in February 1971. He had previously authored CHA-sponsored financing and planning legislation and was regarded as one of the most powerful legislators in the Senate.

The Hospital Disclosure Act received its first major hearing before the Senate Health and Welfare Committee on April 21, 1971 and was unanimously approved. Appearing at the hearing to testify in support of the bill were CHA representatives, the Director of the Department of Health Care Services and a representative of the California Council for Health Plan Alternatives. The only contentious point raised by those testifying on the bill was brought up by a representative of the Kaiser Foundation, who estimated that it would cost Kaiser $1 million to establish the system and $100,000 to $500,000 per year to comply with its reporting requirements. Kaiser objected to being required to file a report under a method geared to fee-for-service hospitals and also to filing a report for each of its facilities. However, representatives expressed willingness to provide the information on a regional basis. A motion to exclude Kaiser from the provisions of the bill was opposed by the Council for Health Plan Alternatives and by the UHA, and was defeated. UHA argued that if Kaiser was to be exempt so should investor-owned facilities. Their view was that the system should apply to all facilities.[27]

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[27] CHA press release April 21, 1971, and interviews with Kaiser and other hospital industry spokesmen.

Subsequently, however, an amendment was negotiated with Kaiser that required the Commission to establish specific reporting provisions for Kaiser hospitals, permitting them to report as a group rather than as individual institutions regarding their balance sheet, income and expense statement, and a statement of source and application of funds. However, cost data were required to be reported for each institution. Comparable modifications were permitted for county hospitals. In the view of CHA this method of reporting would still provide the Commission with adequate information regarding costs for individual institutions and allow valid comparisons to be made. A Kaiser representative was also given membership on the Commission, replacing an accountant.[28]

A major concern of CHA leadership was that the bill would be amended to give the Commission premature authority to regulate rates, a subject that had been discussed at several committee hearings. The bill was not so amended; however, the CHA itself considered an amendment to SB 283 to include rate review and approval because in July 1970 there was concern that Social Security Act amendments being contemplated for inclusion in HR1 and the California Medi-Cal Reform Act (AB 949) might give federal or state officials broader power "to establish rates arbitrarily" for patients benefitted by these programs. Of particular concern was the "possibility of a variety of hospital rate control entities with little or no coordination and little or no hospital participation."[29] This, in the view of CHA leadership, would increase inflationary pressures upon charges for other patients and could even establish the pattern for all patients.

The CHA Board of Trustees therefore suggested amendment of the Hospital Disclosure Act to give the Commission authority to review and approve rates if this was necessary to forestall some unacceptable form of rate regulation. This would be instituted after uniform

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[28] SB 283 as amended in the Senate May 25, 1971.

[29] Minutes of CHA Board of Trustees Meeting July 14, 1971.

reports, under established accounting systems, were filed with the Commission for at least three years. Such an amendment was never proposed, however.

Positions of Interested Organizations

The following describes the positions taken by various organizations and agencies interested in the legislation.[30]

The California Medical Association. The CMA was informed when CHA began specific development of the Disclosure Act. According to one observer, CHA representatives were originally interested in PUC-type rate regulation. CMA objected strongly because they did not favor government control of hospital and services growth, which also might eventually extend to regulation of physicians' fees. CHA initial proposals were watered down significantly to reporting and disclosure.[31] CMA was asked not to oppose the disclosure bill and was assured that one Commission member would be a physician. Since the Commission had no specific authority to regulate rates and might not acquire it for some time, the CMA agreed to remain neutral on the bill while maintaining a watchful position. Some of the CMA's leadership believed that some form of rate regulation might occur and that it made sense to establish a sound basis for it, but CMA lobbyists made it clear they were cool toward the bill because it was an opening wedge into rate regulation and they would not be unhappy if it were defeated.[32]

The United Hospital Association. The UHA, representing investor-owned hospitals, supported disclosure, but some of its members were concerned about the immediate and future effects on them of prospective

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[30]When a specific source is not noted for the position of an organization, our comments are based on interviews with CHA staff.

[31]Interviews with CMA staff.

[32]Interviews with legislative staff and Department of Health Care Services officials.

rate-making and rate regulation. Sherwin Memel's speech at the CHA 1970 annual meeting helped ease their concerns by indicating that neither disclosure nor prospective rate-making would be harmful to investor-owned hospitals since they were at least as efficient as other hospitals.

Kaiser. We have discussed Kaiser's concern about the costs they might have incurred under the reporting system initially proposed. The Kaiser representative on the CHA Board of Trustees went along with the CHA's policy position in favor of disclosure. However, initial efforts to satisfy Kaiser's desire for modifications in reporting requirements were unsuccessful. Although Kaiser would have preferred to be exempt from the bill's provisions, a compromise was achieved during the legislative process and Kaiser sought no further amendments.[33]

Labor. Although the California Council for Health Plan Alternatives initially favored expansion of the Commission authority into rate regulation, they chose to support the Disclosure Act without these provisions. They believed the data generated would be useful, but questioned that a bill containing rate regulatory authority would pass if the CHA opposed it or be signed by Governor Reagan even if it passed. CHPA representatives supported the bill at legislative hearings and helped lobby to get votes for it.

Health and Welfare Agency. The Department of Health Care Services in the Health and Welfare Agency supported the bill on the grounds that uniform cost accounting methods and uniform reporting systems were essential to any realistic approach toward developing reasonable reimbursement rates for in-patient services to Medi-Cal beneficiaries. There was some staff opposition to the bill within the Department of Health Care Services and the Department of Public Health on the following grounds: (1) disclosure provisions should be administered by an executive branch agency; (2) the provisions

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[33]Interview with Robert Erickson, Kaiser Health Plan, June 8, 1977.

allowing hospitals to file Title 18 reports provided a "loophole" to escape more demanding requirements; (3) providing a separate reporting system for Kaiser would not furnish comparable data for all hospitals, and (4) it would take too long to get the system operational. Dr. Earl Brian, then Director of the Department of Health Care Services, believed these staff objections were not substantive and that it was desirable to collect hospital cost data as an accurate base for Medi-Cal rates. He therefore supported the bill.[34]

Other Positions

There was some concern within CHA that the Department of Finance might oppose the bill on the grounds that the industry-sponsored proposal might in the long run result in increased state costs if Commission powers were later extended to set reimbursement rates for state purchasers. However, the Department of Finance favored the bill, primarily because they felt the accounting system to be developed would facilitate a more useful method for price comparison by public agencies purchasing health care services, and a potential leveling off in the rate of hospital price increases.[35] They also wanted better cost data on state and county hospitals for budget analysis. The Legislative Analyst supported disclosure for reasons similar to those of the Departments of Health Care Services and Finance.[36]

Some county hospitals were concerned that major revision in their financial procedures might be necessary. However, with the amendment allowing special provisions for counties needing them, no opposition was expressed by representatives of the counties.

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[34]Interview with Dr. Brian, October 6, 1976, and memorandum of support from the Department of Health Care Services on SB 213, October 22, 1971.

[35]Memorandum of Support for SB 282 by the Department of Finance, October 25, 1971.

[36]Interview with Tom Dooley, Office of Legislative Analyst.

Blue Cross did not take part in legislative deliberations on the bill and took no position on the legislation. However, they did support the desirability of a uniform accounting and reporting system.[37]

Legislative Dynamics

Senator Teale favored future hospital rate regulation and testified that he anticipated it would take the form of public utility regulation. He anticipated that it would take five years to get an accounting and statistical reporting system in place, but that rate regulation would follow.[38]

CHA sold the bill to the legislature as a first step in rate regulation. According to one legislative staffer,

> The CHA-sponsored bill was approved by the legislature primarily because it was viewed as an essential first step toward hospital cost control. Key legislators involved in this issue felt that collection of financial data was a prerequisite for rate control and that the Reagan Administration would not support rate regulation. Therefore, legislators interested in rate control, along with labor unions, were willing to support this measure, because they felt the data generated would be useful. They were willing to leave to future legislatures the task of determining whether or not regulation should be imposed.[39]

The CHA-sponsored legislation had relatively smooth sailing in the Senate after agreement was reached witin the industry on a compromise amendment regarding Kaiser's reporting. The bill passed the Senate in late July 1971. It did not pass the Assembly until October.

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[37] Letter to Commission Executive Director Robert Murch, November 8, 1973, by Blue Cross of Northern California.

[38] Interviews with Senators Teale and Campbell. Campbell served as Chairman of the Assembly Health Committee when this legislation was considered. Interviews, March 22, 1976.

[39] Interview with Bill Barnaby, December 20, 1976.

Several observers suggested that the bill was held in the Assembly to pressure hospitals to refrain from opposing the administration-backed Medi-Cal Reform Act.[40]

In the Assembly, the CHA-sponsored legislation became a pawn in a larger political chess game. Senator Teale, author of SB 283, was opposed to the Reagan administration-sponsored Medi-Cal Reform Act (AB 949, Campbell). During the 1971 session, Republican Governor Reagan and Democratic Assembly Speaker Bob Moretti had formed a political alliance to get both welfare and Medi-Cal reform enacted. Dr. Earl Brian, the administration's chief strategist on Medi-Cal reform, sought to exert pressure on Teale to support administration legislation by amending the substance of SB 283 into the Medi-Cal Reform Act and by holding SB 283 in the Assembly Health Committee.

An added pressure on hospitals to obtain passage of CHA-sponsored legislation was a provision inserted in the Medi-Cal Reform Act which said that providers of Medi-Cal services "shall be required to utilize uniform accounting and cost reporting systems as shall be developed by the department" (of Health Care Services). It provided, however, that if such systems were developed for hospitals based upon "any other provision of law" (i.e., the proposed Disclosure Act), the Department of Health Care Services would be required to adopt these systems. Placing the substance of their program under control of the administrative agency, which was then the state's major purchaser of care for Medi-Cal, was anathema to hospitals.

Only after the Medi-Cal Reform Act passed the Teale-chaired Senate Finance Committee and the full Senate, despite his opposition to it, did SB 283 become dislodged from the Assembly Health Committee.[41] There was no organized opposition to it and the bill was enacted.

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[40] Interviews with CHA and legislative staff. The Medi-Cal Reform Act was the major health issue of the 1971 legislative session. It sought to reduce Medi-Cal costs and provide incentives for creation of prepaid health plans (PHPs), the California version of Health Maintenance Organizations (HMOs).

[41] The provisions of SB 283 were deleted from AB 949 before the Medi-Cal Reform Act was sent to the Governor.

It is important to note that passage of the Disclosure Act came after the imposition of federal price controls. We have not been able to determine the specific effect this may have had on legislative or CHA deliberations, but it is reasonable to assume that federal action spurred industry support for the development of an information base that would buttress their case for "fair" rates.

EXPECTATIONS AT THE TIME OF ENACTMENT

The expectations of those interviewees who participated in the development and enactment of the Hospital Disclosure Act were as varied as their motivations for supporting it.

Professor Morrissey, for example, felt that the development of a uniform cost accounting, reporting and disclosure system would help contain costs in the following ways:

1. It would place pressure on administrators to examine their costs and take action to reduce them because comparable cost data would be available for other similar institutions.

2. Large buyers -- particularly unions and insurance companies -- would see costs. This would encourage competition within the industry and promote enlightened bargaining.

3. A public agency could perform studies to improve utilization and productivity, and encourage efficient use of resources including consolidation of facilities.

The expectations of others are summarized as follows:

- o There would be little direct effect on costs.
- o Data generated would provide a sounder basis for government rate-setting.
- o The industry would buttress its case for higher rates from governmental purchasers.
- o The data would be helpful to planning and Certificate of Need programs.

- o This was the first step toward an independent public utility regulatory body.
- o This action supported by the industry would forestall immediate future efforts to impose rate regulation.

SUMMARY

In sum, hospital administrators in the late 1960s, faced with higher costs which had to be passed on to consumers, were on the defensive. They were unable to explain satisfactorily to public officials, patients, and other large purchasers, such as union welfare funds, why rates were going up or to do anything about it. On the one hand, public agencies, upon whom they were increasingly dependent for revenue, paid them "too little" and along with "consumers" clamored about "high prices, over-utilization, and inefficiency." Doctors, on the other hand, "whipsawed" them to provide increased equipment and services. Increased demand was spurred by new technology and increases in insurance coverage.

This explosion of demand was coupled with pressures for cost containment from consumers and government purchasers. Rates, in the industry's view, were set by government agencies in response to budgetary pressures to hold costs down and with no regard for hospital solvency. In addition, hospitals felt they had no place to go "to make their case" since these decisions were made without their involvement or participation. Overall, many in the hospital field felt that existing government reimbursement formulas and rates were "unreasonable, arbitrary, and unilateral," forcing them to increase charges to nonpublic patients to meet their costs. At the same time they complained about reimbursement rates, the state's fiscal and program agencies criticized the industry for not supplying adequate cost information to justify their requests.

What should be done, then? A number of industry leaders were convinced that government would intervene even more in the financial affairs of hospitals with further expansion of health care financing, planning, and other regulatory actions. They believed hospitals

should take the leadership to shape patterns of governmental action that would be acceptable to the industry; otherwise, unacceptable patterns would be forced upon them.

The CHA thereupon began to examine alternative solutions to its problems. CHA action was stimulated by related developments in the hospital industry nationally, including the AHA Statement of Financial Requirements for Hospitals and the activities of the AHA Perloff Committee stimulating interest in *prospective reimbursement*. Legislative developments in other states and in California also raised the spectre of expanded governmental regulation unacceptable to the industry.

Professor Morrissey was instrumental in helping CHA to define its problems and devise solutions. It became clear to the CHA leadership that fashioning a public body with industry representation and limited initial authority, but which might receive expanded regulatory powers in the future, was in the immediate and long-range interest of the industry. While supporting Morrissey's disclosure proposal, however, the CHA did not accept his suggestions regarding collection of additional financial data (i.e., revenue forecasts and budgets) to support prospective rate-making. Many within CHA were opposed to rate regulation and saw support of the Disclosure Act as a possible way to forestall such control. A substantial effort was necessary to win CHA membership support for the sponsored legislation.

It appears that the CHA's objectives in supporting disclosure by an independent agency were a mixture of the following:

1. To take the initiative and become the architects of governing their financial affairs;
2. To get an accounting and reporting system in place to explain costs, perhaps help improve efficiency, and justify reimbursement rates requested of public agencies;
3. To forestall the state Health Department from future control of rate regulations, since they would likely set lower rates for government than for private programs;

4. To create a body acceptable to the industry that would most likely be the recipient of future regulatory powers bestowed as a result of National Health Insurance or possibly other planning or franchising programs;
5. To promote a system under which all purchasers, including government, would pay the same price for the same service.

Some within the industry saw the creation of an independent agency as the first step toward the creation of a rate regulatory and planning body which they anticipated and supported. Others saw support for disclosure at this time as an important step to forestall immediate and future governmental action to establish hospital rate regulation. Since they were proposing only a first step, there would be time to work with that institution and re-evaluate the CHA's position based upon experience with the administration of disclosure requirements.

Within the legislature, the industry program was supported by those favoring rate regulation as a necessary first step toward achieving that end and because they felt this was the best they could get with the Reagan administration in power. Organized medicine went along with this limited first step, as did administrative agencies that wanted better financial data from hospitals.

Chapter 5
IMPLEMENTATION OF HOSPITAL DISCLOSURE

INTRODUCTION

After the Disclosure Act was passed, the next step was to make appointments to the Commission. Before the Commission could implement disclosure, however, it had to discharge certain responsibilities under the Federal Economic Stabilization Program (ESP); in fact, Commission members met as the State Advisory Board for that program before the Commission was formally organized.

The Commission faced several preliminary problems in implementing the Disclosure Act. It was necessary to design the accounting system that hospitals would be required to install, and the reports they would have to submit. The Commission was then concerned with hospital compliance and the quality of responses. Finally, the Commission had to arrange methods for reporting results and analyzing data received from hospitals.

This chapter examines how appointments were made, how the Commission carried out its federal responsibilities, and the future implications of these decisions. We also discuss how the hospital disclosure system was developed, and implementation issues the Commission faced.

One might intuitively anticipate conflict between hospitals and consumers over disclosure. Hospitals might be expected to resist disclosure because it could generate unwelcome publicity and encourage price discrimination between facilities. Consumers might be expected to want good data produced fast and widely disseminated to help them discriminate between facilities, focus public attention on hospital costs, and provide grist for designing future regulatory programs. We explore whether the expected conflict between hospitals and consumers in fact occurred.

COMMISSION APPOINTMENTS

Some within the hospital industry hoped that the Commission would be "high caliber" and truly independent of both the industry and the government, so that its early activities would lay the foundation for future development of a hospital utility commission. Others expected that appointees would be controlled by the administration and the industry.

To some extent, the character of the Commission had already been determined by statute. The health care industry was sure to have a prominent, if not controlling, role because of their representation on both the 7-member Commission and its Advisory Council.

The Governor's choice of appointees was influenced by Dr. Earl Brian, a physician who served as Director of the Department of Health Care Services when the legislation was enacted and subsequently was named by Governor Reagan to the Cabinet post of Health and Welfare Secretary in May 1972. After having negotiated a compromise which resulted in the enactment of the Medi-Cal Reform Act, a key part of the Governor's program, Brian's stock was high. He consulted with the California Hospital Association to obtain nominees, and it was clear that the Governor would probably approve the slate he submitted. Brian said that, regardless of the Commission's status outside the Health and Welfare Agency, he would endeavor to influence major Commission decisions to the extent he thought desirable.[1]

The Governor appointed the seven Commissioners in February 1972.[2] At its first official meeting on March 8, 1972, the Commission elected Brian's choice, public member Allen J. Manzano, as its Chairman.

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[1]Interviews with Dr. Brian, industry leaders, Governor's office and Departments of Health and Finance staff.

[2]The first appointees were Theodore E. Cummings (public member), Director, Pacific Coast Properties, Inc.; Henry B. Dunlap, Executive Director, Children's Hospital of Los Angeles; A. B. Halverson, Senior Executive Vice President, Occidental Life of California; Allen J. Manzano (public member), President, Health Management Systems, Inc.; Dr. James B. D. Mark, Professor of Surgery, Stanford University School of Medicine; Mrs. Elizabeth Rowen (public member); and Everett Southward, Controller, Kaiser Foundation Health Plan, Inc.

Manzano previously served as Brian's Chief Deputy in the Department of Health Care Services. Manzano had resigned from his state position to establish a consulting firm, and shortly thereafter was selected as a "public member" of the Commission despite his presidency of a firm whose principal business consisted of consultation and other services to health care providers who were negotiating for or holding state contracts to operate Medi-Cal-financed prepaid health plans. After legislative inquiries about potential conflict between his Commission and private roles, Manzano resigned from the Commission on June 22, 1973, indicating that his reason for leaving was a new State law that had been interpreted to mean that no state employee could have an interest in any Medi-Cal contracting firm.[3]

The selections of the hospital administrator and the representative of a prepaid group plan were based on recommendations of hospital groups and prepaid groups (e.g., Kaiser) and there was general consensus among various organizations on appointment of the health insurance representative. Brian was still feuding with the California Medical Association (CMA) over their opposition to Medi-Cal reform and did not appoint the CMA candidate for the physician member. Instead he named a physician of his own choice, a personal friend. He also selected the two other public members, one having served with Brian on a federal health regulatory advisory committee and the other who had served on a State advisory board, had some bookkeeping and accounting background, and had been politically active in the San Francisco Bay Area. The CHA helped to recruit the Commission's Executive Secretary, who was also known to and approved by Brian

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[3] *Los Angeles Times*, May 23, 1974. The Times report commented that, since Governor Reagan named the Commission as the group recommending on hospital exemptions from federal price controls, "Manzano gained economic power over some of the same persons to whom he was attempting to sell his consulting services."

before his appointment.[4] Subsequently, Brian nominated four other members whom the Governor appointed to fill vacancies or expired terms.

In 1973 a new Commission Chairperson, Mrs. Phyllis Smith, was appointed. She had served as Chairperson of the Advisory Council and as a member of several state advisory boards, and had been active in volunteer health and welfare activities. In 1974 a public member, a hospital administrator and a physician supported by CMA were appointed.

According to one observer, "Brian dominated choices of all the people who were appointed to the Commission. He rather bluntly let it be known that these people 'belonged' to him and that he could control Commission decisions."

Although technically made by the Commission, the ten-member Advisory Council appointments were approved by Brian. According to its first Chairman, Brian exercised little direct influence over the Commission's activities except to help get it organized and to help solve administrative problems associated with getting the Commission "up and running." The Commission's work was then largely technical and of no major interest to him.[5] However, Brian had plans to expand the Commission's role. He recommended that it be designated as the State Advisory Board under the Federal Economic Stabilization Program, and soon after its creation was developing legislation to expand its powers.

One unsuccessful attempt was made to bring the Commission directly under Brian's control. Soon after assuming his duties, the Commission Executive Director recommended that the Commission become part of the Health and Welfare Agency in line with the policy of the administration to have all commissions report to one of the Cabinet-

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[4]There was some initial difficulty in securing appointment of the Executive Secretary who was required under the law to have five years experience. This experience requirement was later reduced. Also, a long argument with the Department of Finance over his salary delayed the appointment.

[5]Interview with Allen J. Manzano, May 2, 1977.

level agencies. Although favored by two Commission public members, a motion to accomplish this was tabled after CHA objected on the grounds that this was not the legislature's intent and would require legislation.[6]

Reaction to Appointments

There was mixed reaction to the initial Commission appointments. Within the industry many were concerned that because of Brian's dominant influence the Commission would not be independent of the administration. Instead, it would be subject to executive branch control and "political pressures." Some in the hospital industry felt that several of the appointees were neither prestigious nor knowledgeable enough to be independent of either the industry or the executive branch.

Some of the Department of Health Care Services were glad to see that the industry would not dominate the Commission, and welcomed the appointment of Manzano. Other state officials began to be "suspicious" of the Commission because of Brian's control and industry influence.[7]

THE FEDERAL ECONOMIC STABILIZATION PROGRAM

The Federal Economic Stabilization Program began with a complete freeze on all industries in 1971. Under Phase II, it imposed a 6 percent limitation on revenue increases on institutional providers, with an exception process utilizing State Advisory Boards as local review agencies. Under Phase III mandatory controls were continued on the health industry and lifted from other sectors of the economy. A more sophisticated regulatory system was established under Phase IV but this was short-lived, lasting only from January 1 to April 30, 1974, when all controls were removed.

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[6] Commission Minutes, August 16, 1972.

[7] Interviews with DOH and legislative staff.

The State Advisory Board (SAB) authority delegated to the Commission by the Governor under Phase II of the program was not contemplated by state law nor would the hospital industry have supported it, according to industry leaders, because of its rigid limits on inflationary growth.

A federal Health Services Industry Committee was established to advise on the implementation of price controls affecting the health industry. Dr. Earl Brian and Sam Tibbitts, former CHA President, were named to this 20-member committee. They were strong advocates for local input into the regulatory process and specifically for a state role as an appellate body to review requests for exceptions from the 6 percent price-increase limitation. Such a role was written into federal regulations developed by the advisory committee.[8]

In many states the SAB role was delegated to Comprehensive Planning Agencies. Although California had such an agency in the Department of Public Health, the Commission was assigned this role for a number of reasons. The administration chose not to expand the role of the Department of Public Health because its leadership was not responsive to administration policy. Also, the department was due to be merged with other health units into a unified Department of Health and it was therefore untimely to give it added responsibilities. The Commission already had responsibilities concerning hospital financial affairs and the CHA clearly preferred that such authority rest with the Commission rather than a line executive branch agency. Moreover, since Dr. Brian had led in developing regulations authorizing a state role and also in determining Commission appointments, he was favorable to designating the Commission as the SAB and recommended to the Governor that this be done.[9]

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[8]Interviews with Dr. Brian, October 6, 1976, and Mr. Tibbitts, March 7, 1977.

[9]Interviews with hospital industry, Dr. Brian, and Health and Welfare Agency staff.

State Advisory Board Activity

The Commission met as the State Advisory Board in February 1972. It recognized that in making recommendations to the Federal Price Commission it was expected to evaluate the community service and effectiveness of institutions requesting price exceptions. It viewed this as a "quasi-hospital planning role" since its recommendations constituted assurance to the Price Commission that exceptions would not "simply support inflationary cost increases to perpetuate the continuation of poorly managed or unnecessary institutions."[10]

The Commission performed its SAB role until the end of April 1974. It worked with federal officials in developing state guidelines for the exception review process, which, in California, included the participation of health providers and planning groups. According to the Commission's Executive Director Robert Murch, "We saw during Phase II the strenuous process of control within formulated limits which during that period probably gave hospital administrators more to say about the economic operations of their hospitals than ever before or perhaps ever since."[11] This is probably because they could say "no" to requests to expand services and purchase equipment. Murch said the process during Phase III was more "fine tuned" and "there was an impressive effort on the part of government staff, health industry representatives and leading accounting firms to create in Phase IV a degree of sophistication and control that I believe could have continued as a useful basis for containing health facility prices."[12] The Phase IV program would have provided two options to the states. A state could administer its own total program if it had the authority to administer controls. If it did not have a

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[10] *First Report of the California Hospital Commission to the Governor and the Legislature*, October 18, 1972, p. 2.

[11] *Statement to the Council on Wage and Price Stability* by Robert W. Murch, Executive Director, California Health Facilities Commission, August 10, 1976.

[12] Ibid.

fully operational control program they could manage the exception review process. Under the Phase IV program substantial decisionmaking authority would have been delegated to the Commission to rule on exceptions to industry growth targets set by the federal government. According to Murch, this was a great opportunity missed:

> The beauty of the federal program was that it was announced without warning and hospitals and physicians had no opportunity to raise rates in anticipation of federal controls. Controls were established and there was a need to make them work. The major opportunity missed was the failure to move into Phase IV, which would have been a more permanent system.[13]

The Commission, operating as the SAB, reviewed between 100 and 200 applications for price exception between 1972 and 1974. They denied most of them but recommended more than 35, most of which were approved by the Cost of Living Council.

Implications

Acting as the SAB, the Commission thus gained early regulatory experience that later on helped shape the state's role in controlling hospital cost growth. The Commission began to look into the relationship between hospital rates, occupancy levels, and capital programs in local situations.[14] They saw the need to link Certificate of Need and rate regulation. Exception requests were coming from hospitals that had just completed construction and needed to raise rates to pay off loans. Banks began to demand advance rulings from the Cost of Living Council that future rate increases would be permitted so as to pay for capital expansion. The Commission began to realize how Certificate of Need decisions could force rate increases unless the rate control body was given power to veto those decisions.[15]

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[13] Interview with Robert Murch, April 29, 1977.

[14] Interviews with Commissioners and staff.

[15] Interview with Commission Executive Director Robert Murch, April 29, 1977.

Their SAB role also gave the Commission experience in administering an across-the-board percentage cap on expenditures. According to the former Commission Chairperson, this formula-type approach is unworkable because "it is too simplistic and inequitable." She said the SAB experience taught her that a "more flexible" budget review approach is needed that will screen out unneeded expenditures but provide a basis for differentiating between different types of facilities in different health service areas.

One problem with the federal ESP controls was that hospitals and physicians viewed them as temporary. No major changes were made in operating patterns or long-term decisions. Hospitals used reserves to fund additional activities, and increased their rates when controls were lifted.[16]

THE ACCOUNTING AND REPORTING SYSTEM

The Commission and its Advisory Council considered the development of an accounting and reporting system as its most important accomplishment. Because the task required expertise in hospital accounting and hospital administration, the Commission looked to the industry and its Advisory Council for help.[17]

The Disclosure Act set forth a timetable for Commission approval of accounting systems and the submission by hospitals of historical cost and statistical information. It required that:

- Approved systems of accounting and uniform reporting be adopted and distributed "as soon as practicable" after hearings and consideration of advisory council recommendations.
- After public hearings, the approved accounting system be implemented by affected hospitals beginning 15 months after publication of regulations.

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[16] Ibid.

[17] Interviews with Commission and Advisory Council Members.

- o Hospitals file financial and statistical reports within four months after the end of the fiscal year they implemented accounting systems approved by the Commission.

To fulfill these requirements the Commission developed an implementation timetable. It received suggestions from interested organizations, distributed its proposed accounting and reporting regulations in mid-December 1973, and adopted them in March 1974.[18] As work on the regulations proceeded, it became clear that an accounting manual would be necessary to provide more specific guidance to those responsible for preparing reports. The Commission sought the help of outside consultants to both prepare such a manual and advise it about ways in which to publicly report on the information gathered from hospitals. The Commission also sought additional advice about alternative ways a financial data system might be developed and used.[19]

The hospitals began to file their annual reports in the fall of 1975, whereupon the Commission compiled three types of reports: (1) an individual hospital report (Series A); (2) an individual hospital report for those facilities submitting Medicare Title XVIII cost reports in lieu of those required by the Commission (Series B); and (3) a statewide inventory presenting statistical and financial data by type of hospital ownership and health service area (Series C).

THE MAJOR ISSUES

One purpose of the Disclosure Act was to enable comparison of hospitals' performance.[20] To that end, the Commission wrestled with a number of problems.

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[18] Ibid.

[19] Ernst and Ernst assisted the Commission in developing its accounting manual and hospital reporting system.

[20] *California Health Facilities Disclosure Act*, Sec. 441(b).

Exemptions

One problem was to determine the accounting and reporting requirements that would apply to Kaiser and other group practice prepaid plans, county hospitals, and state hospitals.

Kaiser was authorized by law to use its own accounting system and to report certain financial data as a group. Some Commission and Advisory Council members wanted Kaiser to report data that could be compared with those of other hospitals because they felt these other facilities would benefit from Kaiser's experience. Kaiser, on the other hand, was concerned about having to keep two sets of books, one for their own purposes and the other for the Commission. The Kaiser representative pointed out that revenue received could not be identified by hospital or applied to specific medical and hospital services, since 80 percent of total revenue was derived from prepaid subscribers and allocated on a regional basis to meet the financial requirements of each hospital.[21]

County and state hospitals operating on a budget system (as opposed to an "enterprise" system) argued they could not submit a balance sheet or statement of changes in equity or financial position. The Commission agreed to exempt county and state hospitals from these reporting requirements, but Commission regulations "encouraged" them to "move toward full compliance with all regulatory reporting requirements."[22]

In addition to the foregoing exemptions, some interviewees in the DOH and the legislature were disturbed about the general exemption granted to all hospitals to file their Title XVII Medicare reports instead of those prescribed by the Commission. Widespread use of that method, they believed could preclude the collection of comparable data.

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[21]Advisory Council Minutes, February 8, 1973; Commission Business Regulations, Secs. 7024 and 7044.

[22]California Health Facility Commission regulations, Title 4, Business Regulations, Chapter 10, Article 3, Sec. 7044.

Some attempts were made to nullify the exemption, but very few hospitals used it anyway and it is still part of current law.

Proposed Statistical Reporting Delay

When the CHA presented its recommendations for implementation of disclosure at the Commission's October 18, 1972 meeting, it requested that the Commission defer action on the cost allocation and statistical reports required by the Act, for fear that premature release of such information would lead to misleading, inaccurate, and confusing comparisons between hospitals. The CHA anticipated that its own Hospital Effectiveness Demonstration project would provide a basis for regulations governing this type of reporting. Also, according to one industry spokesman, "some within the industry were resistant to moving fast on disclosure."[23] Commissioner Halverson chided CHA representatives:

> I don't think that we'll have the luxury of waiting two years to complete your study on statistics. And there is no reason why it can't be done before that time . . . I hope we can start with some basic information we can agree on and get the do-gooders off our backs. I think it is essential we get on with it.[24]

The Commission rejected the CHA request, and instead called upon hospitals to make recommendations on the form and content of these reports before a formal adoption of regulations. This was done during 1973.

Quarterly Reporting

To provide for early public disclosure and improve the comparability of data, Commission staff recommended that (1) hospitals be required to file certain financial and statistical reports on a

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[23]Hospital industry interview.

[24]Minutes of Commission Meeting, October 18, 1972.

quarterly rather than annual basis, and (2) hospitals choose one of four specified quarterly fiscal periods rather than report annually at the end of the fiscal year. According to the staff, these changes would enable more accurate comparisons both between hospitals and over time, since changes over quarters could be measured, and such data would be more useful to both hospital administrators and large purchasers of service.[25]

Hospitals objected to these changes on the grounds that they departed from the law, which called for annual statements, and placed an additional reporting burden on them that might not produce better data. They also were concerned that the proposals were made by staff without consulting the hospitals, thereby damaging the cooperative relationship between the Commission and the industry necessary to get the system off the ground. The Commission voted against the proposed changes and subsequently voted to oppose insertion of quarterly reporting in the regulations.[26]

Patient Care and Intensity of Service Data

The Department of Public Health said the Commission's proposed regulations would not enable legitimate cost comparisons because there would not be adequate data "accounting for differences in cost due to differences in case mix, number and complexity of services and age distribution of patients."[27] The matching of adequate data on patient care with the accounting system could produce data that would allow

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[25]A January 22, 1973 memo to the Commission by Executive Director Robert W. Murch recommended quarterly reporting. The staff recommendation was made after discussion with Dr. Ingbar, the Commission's health economist consultant. See Advisory Council Minutes, January 16, 1972.

[26]California Hospital Commission Title 4 Business Regulations, Chap. 10, Art. 3, Sec. 7044.

[27]Letter to Robert Murch, Commission Executive Director, from Saleem Farag, Chief, Comprehensive Health Planning, Department of Public Health, January 22, 1973.

comparative analyses to be undertaken on the cost per patient day, per episode, and per unduplicated patient. These analyses could also help explain differences in such costs with respect to the pattern of treatment and the character of clientele in a given hospital.[28]

Some Commission staff had similar concerns and an opinion was requested from the Attorney General asking if the Commission could by regulation require the inclusion of patient characteristics as part of the statistical reports authorized by law. The Attorney General said the Commission had this authority.[29] Since collection of these data was not specifically mandated by law, however, and would place a burden on hospitals, the Commission chose not to require these reports. However, its 1976 annual report recommends that legislation authorize the Commission to obtain "non-identifiable patient case data."[30]

Disclosure of Physician Remuneration

Hospital-based physicians who were on salary or who billed through a hospital were concerned about the disclosure of their individual incomes. One radiologist commented that:

> I'm afraid that this requirement would have the effect of driving hospital-based physicians to a method of billing completely independent of the hospital's financial operation. It will clearly create a good deal of unrest and may widen the chasm that already exists between hospital administration and physicians.[31]

In adopting its regulations in 1973, the Commission had resisted efforts by physicians and CHA to remove the requirement that this

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[28] Ibid.

[29] Attorney General Opinion No. CU 63/15412, October 10, 1973.

[30] *California Health Facilities Commission Annual Report to the Governor and the Legislature, November 1, 1976, p. 4.*

[31] Letter to Commission dated October 2, 1973.

information be itemized. In 1975, over the objection of public members, it removed the requirement by regulation change. The justification was that many physicians were billing separately, causing confusion among patients and loss of revenue to hospitals, who previously served as collection agents for these funds.[32]

Disclosure of Hospital Administrator Salaries

The Commission initially required the disclosure of hospital administrators' salaries, despite CHA opposition, to be consistent with Medicare cost reports. (After Medicare later removed this requirement, so did the Commission.) The issue had been raised when the Commission considered its proposed manual for nursing homes in 1976. Medicare did not require disclosure of nursing home administrators' salaries. The matter was referred to the Advisory Council, which recommended, for the sake of consistency, that the requirement to disclose hospital administrator salaries be deleted.[33] The reason given was that disclosure would encourage competition for administrators and cause salaries to go up. Over the objection of two public members, the Commission voted not to require individual disclosure of hospital administrator salaries.

Reporting Commission Data

Public release of hospital data by the Commission has been a sensitive matter. It has been criticized for taking too long to develop and disseminate results. Some Commission staff share the view that dissemination of results was not pushed by the Commission until the appointment of new Commission members by Governor Brown.

The design of report formats was initially assigned to an outside contractor, who was requested not to work with CHA in developing them.

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[32]Commission Advisory Council Minutes, February 5, 1975, and interview with Robert Murch.

[33]See Commission Minutes, September 2, October 5, and November 17, 1976.

In the fall of 1974, Commission staff requested Commission authorization to proceed on the design and development of the Commission reporting system based on sample reports then received from hospitals. Hospital representatives felt this was a "bad system" and requested that report design be delayed until complete data from hospitals were received; otherwise, in their view, the reports would be incomplete, misleading, and unfair to hospitals. They felt the Commission staff was pushing prematurely for early output to demonstrate the Commission's accomplishments, and suggested that a committee be appointed to make recommendations to the Commission on this matter. After review by the Commission's Advisory Committee, a Reports Committee was appointed early in 1975 to develop report formats based upon review of disclosure reports from hospitals; the committee included representatives of Blue Cross, private insurers, hospitals, and the legislature. Commission public members supported the need for delay to produce accurate reports.

The Reports Committee, according to one member, worked to design a system that would produce accurate data not susceptible to misinterpretation. They hoped that the data would be useful to hospitals by permitting them to compare their costs with those of other institutions, and to planners concerned with occupancy levels and appropriateness of services as a basis for future rate setting.

The Commission released data from its first annual inventory in March 1977.[34] In addition to presenting statewide data, the inventory was designed to serve as a basis for comparing individual hospitals with statewide or hospital groupings (e.g., bed size, health service area, type of ownership).

New Commissioners appointed by Governor Brown have encouraged dissemination of Commission data. For example, the Commission recently prepared a special report for use by local planning and community groups that details costs and revenues for all hospitals by name. The

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[34]California Health Facilities Commission, *First Annual Inventory of Financial and Statistical Information For California Hospitals* (undated).

reconstituted Commission has also repealed the previous requirement that hospitals be notified who is requesting their reports.[35]

Auditing

Several critics have questioned the validity of Commission data because the extent to which hospitals are using the prescribed accounting systems or reporting accurately has not been verified by audit.[36] Commission staff members estimate, however, that 80 percent of the hospitals are using the mandated system, based on their review of completed reports. The Commission's Executive Director believes that the processing system contains adequate checks to assure reasonable accuracy of reporting, and that it would not be cost effective to establish an auditing system.[37] Even though the law mandates the Commission to establish an approved audit system and some staff have favored it, no proposal has been made to the Commission to implement this authority.[38]

Participation of Other State Agencies

The Disclosure Act was also intended to generate data to be used by other state agencies, particularly the Department of Health, which reimburses hospitals under Medi-Cal, and the Department of Benefit Payments, which audits hospitals to determine if reimbursement requested by hospitals in their cost reports will be allowed. However,

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[35]The mission statement adopted at its August 22, 23 meeting called for emphasis on dissemination of Commission data. Also the Commission-prepared 1978-79 budget calls for creation of a new Public Information and Consumer Outreach Unit. The special report referred to is California Health Facilities Commission, California Hospital Data for Health Systems Agencies, 3 vols., October 1, 1977.

[36]Interviews with legislative staff and Health Department officials.

[37]Interview with Robert Murch, May 29, 1977.

[38]Section 441.16(c) mandates the Commission to establish an approved auditing system. Interviews with Commission staff.

these agencies had little or no input into the design of the Commission's accounting and reporting system.[39]

After the Commission's accounting and reporting system was developed, consideration was given to whether the disclosure reports could be modified to meet the audit needs of Department of Benefit Payments, and a single system developed. It was determined that this would require substantial effort and cost to the Commission, and the matter has not been pursued.[40]

OTHER ISSUES

Other accounting and reporting provisions which aroused controversy were:

Mandatory specific account numbers. This level of detail was resisted by some hospitals, although favored by CHA. The Commission's regulations required that all hospitals implement the auditing structure by July 1, 1977. The three-year delay was allowed to compensate for the extensive computer reprogramming required for some large hospitals.

Standard unit of measure. CHA requested delay in implementing statistical reporting on a Relative Value Unit (RVU) basis for lab and x-ray services, on the grounds the RVU system would make it difficult to account for differences among hospitals. It was argued that some sort of weighting should apply, and that even though RVUs were "not totally satisfactory," they should be used pending establishment of more appropriate RVUs on a hospital-wide basis.[41]

Delay in reporting labor costs. Labor cost requirements were delayed one year to ease the first-year reporting burden on hospitals.[42]

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[39] Interviews with Commission staff, Department of Health, and Department of Benefit Payments.

[40] Interview with Department of Benefit Payments staff.

[41] Memo by Robert Murch, Executive Director to Commission, September 21, 1973.

[42] Murch interview.

CALIFORNIA HOSPITAL ASSOCIATION ROLE

Soon after the Disclosure Act was passed, the CHA prepared for its implementation. Having initiated the legislation, the CHA had a heavy stake in the work of the Commission, and took steps to help the Commission develop an accounting and reporting system.[43]

The CHA's Financial Management Committee and Special Resource Committee, with the assistance of consultants, examined problems of implementation from the standpoint of both finance and overall hospital administration. Efforts were also made to work with different types of hospitals to identify problems they might have in conforming to provisions of the law.[44]

After reviewing the suggestions of these committees, the CHA adopted recommendations and an overall policy posture toward the Hospital Disclosure Act, which were transmitted to the Commission. The CHA pledged its support for the Commission; it also expressed support for prospective budgeting, noting that the federal Phase II price control program required budgeting, and indicated its intention to encourage all hospitals to move in this direction. To assist in developing factual data for financial disclosure and price control, CHA announced the formation of a Division of Research and Advocacy to be headed by Association past president Gordon Cumming. Under Cumming's direction, the Association would be conducting a two-year, federally sponsored Hospital Effectiveness Demonstration Project to develop a prototype system for measuring and comparing hospital costs and predicting the demand for hospital services.

According to hospital industry interviews, the CHA did the basic developmental work for the Commission's disclosure system.

There was some conflict within CHA about how far to go in reporting data, however. As noted earlier, some within the industry urged going slow on disclosure. Others wanted additional data in the

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[43] Interviews with CHA staff.

[44] Ernst and Ernst, consultant for CHA, was later hired to help design the Commission's accounting and reporting system.

reporting system, such as detailed labor costs (delayed one year) and case mix, quarterly reporting, and disclosure of budgets. According to interviewees, CHA eventually viewed these efforts as premature.

The Commission welcomed CHA's efforts. Its Advisory Council endorsed the philosophy of a cooperative venture between the hospitals of the state and the California Hospital Commission and expressed its appreciation "to CHA for having developed the proposal [accounting and reporting] and having achieved a remarkable consensus of opinion in the face of such widespread diversity of hospital operations."[45]

VIEWS TOWARD THE SYSTEM

Despite some criticism and problems, most persons interviewed, including those in the DOH and the Department of Finance, credited the Commission with having done a good job in developing its accounting and reporting system. Its output appears to be extensively used by DOH planning staffs and, according to Commission staff, the California system has been used as a model by other states and by the Social Security Administration in helping to fulfill its mandate.[46]

The major problems noted by persons interviewed or in the Commission's own studies are:

1. Errors in reporting during the first year of implementation.

2. Difficulty in comparing balance sheets because some hospitals are not charging costs to the appropriate cost centers. This leads to non-comparability, which may be remedied after more experience with use of the system.

3. Lack of data on case mix. This precludes direct comparison of inputs and outputs. This can, to some extent, be surmounted by grouping similar hospitals.

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[45] Memo from Subcommittee on Reporting and Statistics, November 9, 1972.

[46] A comparison of the proposed draft federal accounting manual and the California manual reveals substantial similarity between the two. The description and definition of the Chart of Accounts and the Balance Sheet in both manuals are almost the same.

4. Non-comparability resulting from use of Title 18 reports by some 50 hospitals (including prepaid group plans). This can be remedied by removal of the Title 18 exemption.

5. Non-comparability because of different fiscal periods. This can be remedied either by quarterly reporting or applying an appropriate discount rate to adjust for different time periods.

6. Failure to disclose data on all physician transactions in the hospital so that the cost of different procedures can be measured.[47]

7. Lack of auditing to verify use of uniform accounting and accuracy of reporting.

The Commission itself has recommended elimination of the Title 18 exemption and collection of patient mix data. It is reasonable to expect that many errors in reporting will be corrected with time.

THE EFFECTS OF DISCLOSURE

It would be difficult to evaluate the effects of disclosure in any event, but almost impossible to do so given the short time that the Commission's data have been publicly available.

At a recent Commission meeting it was estimated that over 900 requests for disclosure reports had been received. Organizations requesting reports included planning agencies, labor unions, consulting and research organizations, consumer groups, and hospitals.[48]

Opinion is divided among those interviewed as to whether disclosure has had or will have any measurable effect on hospital cost containment. Commission members feel that, while savings are likely to be minor, local facilities will be held more accountable and will have to justify their costs, given sufficient publicity and attention by third-party payors and consumers. One Commissioner commented, "Since 15 to 20 percent of costs are controllable by the administrator,

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[47] See also John Chambers, *Economic Analysis of Disclosure: Data, Progress and Problems*, June 30, 1976, prepared for the Commission by its staff economist.

[48] Minutes of Commission Meeting, August 22, 1977.

public disclosure will put pressure on administrators to justify their costs to their boards and the public." However, another Commissioner believed the effect would be modest, since units of service are controlled by the physician.

SUMMARY AND CONCLUSIONS

Decisions concerning appointments are an important key to understanding the Commission's behavior. In choosing appointees, the competing interests were those of the industry, which had structured a law to assure its participation, and the administration, which sought to assure a Commission responsive to its will. Persons affiliated with consumer organizations were not vigorously recruited. At the time the Commission was created, consumer advocates in the health field were probably few and far between, and appointment of consumer advocates probably would not have fit the style of the administration.

Public members were chosen in the light of their past service on state advisory or volunteer boards, past association with Dr. Brian, and their political activities. The Executive Director, who was required by law to be a hospital administrator, was recruited by CHA, but also was previously known to Dr. Brian.

Many within the hospital industry were concerned that, because of Dr. Brian's dominant influence, the California Hospital Commission was not "independent" of executive branch operating agencies and political pressures. Other interested in the Commission's work felt it should be independent of both the industry and the government, and prestigious enough to withstand pressures from both, but contended that the appointment process made this "Brian's Commission."

Despite some concern about executive branch domination, the Commission was structured to assure strong industry participation. Hospital administrators were members of the Commission, and hospital interests were represented on the Advisory Council. Moreover, the Commission's most important early task was to develop a uniform system of cost reporting, a technical task not likely to command the attention of governmental leaders.

The Commission developed its accounting and reporting system with the cooperation and assistance of the hospital industry. The DOH was not consulted, but consumer organizations paid little attention to the system and consumer groups did not attend Commission meetings. Even though the labor-sponsored California Council for Health Plan Alternatives (CCHPA) had championed disclosure, it paid little attention to its implementation. Consumer members of the Commission relied primarily on the industry and their Advisory Council for help in carrying out this task. Consumer groups became active in the Commission's work only after Governor Brown made appointments to the Commission and consumers felt they had a friendly ear.

The implicit objectives of the hospital industry appeared to be (1) to help the Commission get a good accounting and reporting system up and running to assure Commission "success"; (2) to get cost data developed that would support the industry's case for higher rates from the government; (3) to control the data system by exercising primary influence in its development; and (4) to promote delay and avoid the potential embarrassment of prematurely disclosed comparative hospital data when it appeared in the industry's interest to do so. The industry appears to have achieved all these objectives.

Federal action to impose price controls strongly affected the Commission's work and the hospital industry. The Commission was given responsibilities that influenced its later positions on state health facility regulation. The industry had to live with federal regulations that many did not like. The importance of the Commission's tasks was highlighted by industry leaders' conviction that price controls on hospitals would be continued. The data the Commission collected therefore would be useful not only for disclosure but also as a basis for future budget and rate review.

The Commission faced a number of issues in developing the disclosure system to fulfill its statutory mandate to produce uniform comparable data. How detailed should the system be? How much information should be collected? How should it be disclosed? The law permitted hospitals to file their Title 18 Medicare cost reports in

lieu of those mandated by the Commission, and special provisions applied to prepaid health service plans and counties. Statistics on patient mix of hospitals were not required and labor statistics were delayed a year. Hospitals objected to staff-proposed quarterly reporting, and this was rejected. The Commission rejected the industry's request for delay in implementing statistical reporting. Although initially included in its 1973 regulations, requirements for disclosure of income of hospital-based physicians and hospital administrators' salaries were deleted by subsequent regulation changes. The hospitals had to implement the Commission's accounting system to begin filing reports. The Commission then had to wrestle with the sensitive issue of what kind of data it would publish and in what form. Hospitals were concerned that misleading and inaccurate data might be produced and fought successfully for delay and the establishment of a Reports Committee to recommend report formats. The first annual inventory of Commission data was published early in 1977.

The hospital industry, through CHA, was instrumental in developing the accounting and reporting system. Industry leaders also worked hard with their members to win acceptance of the Commission system.

Most observers interviewed believe the Commission produced a good accounting and reporting system. Many suggested that improvements are needed to promote comparability, such as patient mix data and elimination of the Title 18 exemption. Some critics are suspicious of the data because conformance with Commission mandates had not been audited. It is difficult to say how differently disclosure implementation may have proceeded if consumer advocacy groups had been actively interested in it. Because they were not, however, the industry was left with a clear field to pursue its own interests.

It is too early to assess the effect of disclosure on cost containment. Most of those interviewed believe the effect will be modest, but that it will promote accountability if reports receive publicity and are widely disseminated.

Chapter 6
LONG-TERM-CARE DISCLOSURE

INTRODUCTION

For some years, investor-owned skilled nursing facilities that depended primarily on state Medi-Cal support were interested in coming under the Commission's jurisdiction. Like hospitals, they believed the long-term-care industry would gain public confidence from disclosure and also secure fairer reimbursement rates from the government. They also anticipated that the Commission would set rates, and wanted representation on it. This chapter discusses the history of legislation that expanded the Commission's authority to include long-term-care facilities, and the Commission's effort to implement uniform accounting and reporting for nursing homes.[1]

NURSING HOME LEGISLATION

Investor-owned nursing homes, represented by the California Association of Health Facilities (CAHF), were interested in coming under the Commission's jurisdiction soon after it was created but both the Commission and the hospital industry were opposed. The Commission favored educating itself by working with hospitals first, since they were "more sophisticated in accounting technology" than nursing homes.[2] The initial legislation excluded nursing homes partly because hospitals contended that the Commission would have to devote most of its time to these more numerous and less sophisticated institutions while hospitals were paying most of the fees to support the Commission.[3]

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[1] Most long-term care is provided in three types of facilities. (1) The Skilled Nursing Facility (SNF) provides comprehensive medical care and supportive services to ill or disabled persons on a continuing basis; (2) the Intermediate Care Facility (ICF) provides care to those requiring intermittent nursing care and supportive services; and (3) the Residential Care Facility (RCF) provides services for those not requiring nursing care.

[2] *Annual Report of the California Hospital Commission*, October 18, 1972, p. 2.

[3] Analysis of AB 1812, prepared by the staff of the Assembly Health Committee, May 7, 1975.

Investor-owned facilities, representing 90 percent of all nursing homes, were strongly motivated to support legislation that might lead to higher reimbursement rates from the state government, the source of the lion's share of their income (about 65 percent of all nursing home patients are on Medi-Cal).

A number of industry leaders we interviewed said the industry was being judged by a few "bad apples" and wanted to show the public that nursing homes were "not profiteers" by "laying our cards on the table." They hoped public disclosure would allay the fears of public agencies that increased state funding for investor-owned facilities would go into windfall profits and not better care.

Nursing homes regarded the state's rate-setting process as arbitrary. In their view, the state used low-cost and therefore poor facilities as a guide, and the rates were largely based on the Department of Finance's determination of how much they wanted to spend rather than the legitimate needs of the nursing homes.[4]

The nursing homes challenged the state's rate-making process, and in 1970 the courts ruled that there must be an evidentiary basis for setting rates. Nursing home leaders became convinced that a uniform accounting and reporting system was needed to provide comparable cost information that would justify fair rates. The hope of some was that future rates would be set by an independent Commission separate from the Department of Health.

Nursing home leaders felt it would be advantageous for nursing homes to be part of an independent Commission that would set rates prospectively for all health facilities. They were upset over their exclusion from the economic stabilization provisions of the Hayden Bill (AB 2123) which, as enacted in 1973, applied only to hospitals.

Nursing Home Disclosure, AB 4396

In 1974 Assemblyman Ingalls introduced AB 4396 at the request of the CAHF. As introduced, it renamed the Commission the California

[4]Nursing homes are reimbursed by Medi-Cal on the basis of flat rates per day set by the state, rather than on the cost basis applied to hospitals.

Health Facilities Commission and expanded its membership from seven to eleven members (five from the health industry, including one from an investor-owned skilled nursing home, one from health insurance, and five public members) and required the Commission to develop an economic stabilization program for all health facilities.

The bill was supported by hospitals. Although the California Association of Homes for the Aging (CAHA) did not initially support the CAHF bill because it had developed its own accounting manual used by most nonprofit homes, CAHA, representing nonprofit homes, later endorsed the bill in principle if nonprofit nursing facilities were to be represented on the Commission.[5] The most controversial aspect of the bill was the makeup of the Commission. An amendment to AB 4396 expanded the membership of the Commission to fourteen, including a representative of nonprofit homes and additional public members. However, nonprofit-home membership was amended out of the bill and, as passed, AB 4396 provided for thirteen members, permitting one of the public members to be a board member of a nonprofit home. According to CAHA, this was a last-minute change put in at the request of CAHF and CHA. CAHA urged the Governor to veto AB 4396 because it "so blatantly favors one segment of the industry."[6]

The nonprofit homes likened their position to that of Kaiser hospitals in that they had special agreements with their residents under life-care contracts. They also opposed paying fees without representation on the Commission. In their view, separate representation was needed because most nonprofit homes were primarily residential care facilities and should not have to conform with reporting and accounting requirements designed for facilities that were primarily nursing homes.[7] The Governor signed the bill after its author agreed to sponsor a bill for CAHA giving it membership.

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[5] *CAHA News*, Fall 1974, p. 9.

[6] Letter to Governor Reagan from Peggy Schuler, CAHA Director of Government Relations, September 6, 1974.

[7] Undated CAHA communication to its members in Assembly Health Committee file on AB 4396.

Changing the Commission's Membership, AB 1812

Rather than seek representation on the reconstituted Commission, CAHA developed its own legislation in 1975 to establish a separate commission to provide for a uniform accounting, reporting, and disclosure system for the entire long-term-care industry.[8] CAHA justified its program on two grounds:

1. The "medical model" used to judge health care should not be applied to facilities that provide a wide range of "psychosocial" services delivered by nonmedical personnel, such as social workers. These services do not fit the medical model and are not paid for by government programs. (The Commission's Executive Director agreed with this reasoning.)

2. The needs of nonprofit homes were not adequately recognized on the present Commission.[9]

After both CAHF and CHA opposed a separate commission, and Assembly staff questioned the desirability of this approach, it was dropped. The CAHF position was that "hospital oriented people" would not dominate the existing Commission, since a majority would be public members, and that all health facilities should be regulated by the same agency.[10] AB 1812 was then amended to increase the membership of the existing Commission to fifteen members by the addition of a nonprofit nursing home representative and an additional public member. The bill passed with no opposition.

IMPLEMENTATION OF NURSING HOME DISCLOSURE

Greater problems are to be expected with implementing uniform accounting and reporting for long-term-care facilities than for hospitals because there are twice as many of them, and many are small and

[8] California Association of Homes for the Aging, *Proposal for a Long-Term Care Commission,* 1975.

[9] Ibid., pp. 2-4.

[10] Letter of opposition to AB 1812 from CAHF, May 5, 1975.

unsophisticated in their fiscal management. Also, about 6 percent of the facilities provide residential care in addition to skilled nursing or intermediate care services. Most of these facilities do not maintain separate accounts for different bed categories.

The initial implementation of uniform accounting and reporting systems for the long-term-care industry proceeded differently than for hospitals. The system was developed without representation of nursing homes on the Commission, since Governor Brown failed to make authorized additional appointments. Some hospitals grumbled about Commission rules, but generally accepted them. However, the initial effort to develop accounting and reporting systems for nursing homes was greeted by major protests from the industry. The Commission staff and the contractor were sent back to the drawing boards to develop a system acceptable to the nursing home industry.

The industry voiced its objections at the February 6, 1976 meeting of the Commission's Advisory Council, called to review the first draft of the Accounting Manual prepared by the Commission's consultant, Arthur Young and Company.

The major objections of investor-owned facilities were that the proposed system was too complex and costly (a view supported by the DOH), and was inappropriately modeled after the Commission's hospital accounting system. A CAHF representative also complained that the system had been developed without the participation of long-term-care industry representatives who had not yet been appointed to the Commission and its Advisory Council. The Commission was also criticized for the late involvement in and review of the system by the DOH, which would have to approve costs of implementation. It was estimated that facility accounting costs would rise by 75 percent; a "conservative" estimate was $5000 per facility to implement the system and $8500 to maintain it.[11]

A major concern of the nonprofit homes was that residential care facilities which also had relatively few nursing home beds would be

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[11] Letter to Advisory Council Chairman Wallace Jamie from Robert Gerst, Counsel for CAHF, February 6, 1976.

forced to develop the Commission-imposed complex accounting system. Many of these facilities had life-care contractual requirements that necessitated their having small licensed skilled nursing home facilities (usually fewer than 50 beds).[12]

After hearing from the nursing home industry, the Council recommended to the Commission that implementation of the system be delayed six months from July 1, 1976 to January 1, 1977 and that the manual be modified to meet industry objections.[13] This recommendation was accepted and the contractor and Commission staff were requested to develop a system acceptable to the industry.

The revised manual does not require nursing homes to use specific accounting numbers as hospitals must do. The facilities have the option of using (1) the mandatory reporting level chart; (2) an optional chart; or (3) their own chart of accounts supplemented by a conversion table. According to the Commission, the revised manual does not require nonprofit homes to break out nursing home assets and liabilities on their balance sheet and to report costs for these facilities jointly.

The revised manual was endorsed by CAHF and CAHA, and was adopted by the Commission in September 1976. All long-term-care facilities were required to implement the system by January 1, 1977. The first reports are to be generated after April 1978 and a full reporting cycle is to be completed by April 1979. According to the Commission's 1976 Annual Report, California "will be the first and only state with a mandated uniform accounting and reporting system" for hospitals and nursing homes.[14]

VIEWS TOWARD THE SYSTEM

Commission staff members disagree about the usefulness of the revised nursing home accounting and reporting system. According to one Commission staff member we interviewed, the adopted system

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[12] Letter to Advisory Council Chairman Wallace Jamie from Northern California Presbyterian Homes, Inc., James M. Muzzy, Controller, February 5, 1976.

[13] Minutes of Advisory Council Meeting, February 6, 1976.

[14] *CHFC Annual Report*, November 1, 1976, p. 6.

> makes it difficult to make cost comparisons between facilities. The cost centers are so gross that it is difficult to know what's in them and it is very hard to relate costs to specific activities. It does not include adequate units of measure. . . For combined facilities one cannot determine those items for skilled nursing activities as opposed to residential care. Lack of mandated accounting numbers will hamper auditing.

He said that after staff were instructed to work with the industry they "gave them everything they wanted." Top management felt that the nursing home industry should not "be pushed too hard at the early phases" and "the system would be tightened up later." The nursing homes would have accepted a "stronger system if the Commission was tougher in negotiations with them."

Another Commission staffer was convinced that the system designed for hospitals was not appropriate for nursing homes and, if they failed to accept it, it would not work. As he said to the interviewee, "The system will yield comparable data but at the same time is an optional and flexible one developed with the support of an industry which is relatively unsophisticated."

The manual finally developed provides for a much simpler system than that developed for hospitals, but industry interviewers are confident it will enable valid cost comparisons because there is a standard reporting system. It is estimated that implementation will cost $1000 per facility and about $300 to $400 per year.[15]

SUMMARY

Nursing homes, like hospitals, were responding to pressures to cut costs, but in a system dominated by a single government purchaser, the state Medi-Cal program. They also wanted to refute arguments that "profiteering" investor-owned nursing homes were "ripping off" both the aging and the government. Since their rates were already set by

[15] Commission Public Hearing No. 3, September 14, 1976.

the DOH in what they considered to be an arbitrary fashion, they favored rate setting by some other agency on which they might obtain representation.

After investor-owned nursing homes chose to sponsor disclosure legislation (AB 4396, Ingalls), the major issue during the legislative process was the membership of the Commission. Compromises between hospital and nursing home groups resulted in adding investor-owned facility representation, but an amendment was also added giving public members a Commission majority. This compromise was not satisfactory to nonprofit homes and they were able to gain representation the following year (AB 1812, Murphy). The primary effect of legislative action was to ratify the desire of nursing homes to become part of the regulatory process initially designed by and for hospitals.

The process of implementing nursing home disclosure differed from that of hospitals. Governor Brown failed to appoint additional nursing home representatives to the Commission, and the Commission was initially inclined toward producing an accounting and reporting system for nursing homes similar to the one for hospitals. When nursing homes protested, the process of compromise seemed to reflect bias toward the nursing home industry since the primary interest was to develop a system the industry could live with. This bias was reinforced by lack of active consumer involvement in Commission deliberations. The central objective that emerged was to devise a system that would bring most nursing homes up to the financial accounting and reporting standards of "the better homes." However, it is too early to judge the effects of nursing home disclosure since nursing home reporting under the new system takes effect next year.

Chapter 7
RATE REGULATION AND CAPITAL EXPENDITURE CONTROLS

INTRODUCTION

Capital expenditure and services controls (CES) are usually contained in state Certificate of Need laws requiring approval of capital projects by area planning agencies. The 1974 National Health Resources Planning and Development Act (PL 93-641) required the states to set up Certificate of Need programs and regional Health Systems Agencies (HSAs) within four years. Therefore, California, like other states, has been under federal mandate to pass implementing legislation.

Rate regulation usually embodies a process whereby a nonhospital authority reviews and approves or sets limits on hospital budgets or rates, prospectively (i.e., for a future defined period). The review process may be mandated by state law, imposed by contractual agreement, binding on the institution, or purely advisory. The rate-setting process may use one or more of four review methods: review of individual hospital budgets; review of individual hospital budgets that exceed specified amounts of costs or other measures (i.e., review by exception); a formula that differentiates between hospitals; and negotiation with individual hospitals or groups of hospitals. Hospitals generally have preferred individual budget review and negotiation over the formula approach favored by many government agencies that purchase care. Hospitals argue that any regulatory process must account for differences between hospitals, while proponents of a formula stress its simplicity and, if tightly drawn, the greater likelihood of its achieving cost containment.

According to an American Hospital Association survey, rate regulatory programs are administered in 25 states by state agencies, Blue Cross plans, or state hospital associations.[1] Blue Cross plans

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[1]American Hospital Association, *Report on Rate Regulatory Programs*, January 1977. Rate regulatory programs were defined as those which monitor, review or establish rates, charges, costs, or revenues of health care institutions.

participate in these programs in 22 states, either through negotiated prospective reimbursement contracts or as part of a state-established regulatory system. Of the 25 states with rate regulatory programs, 22 use a budget review method. Only one state, New York, relies solely on a formula approach. Three other programs use a formula in combination with budget review. Two programs rely solely on negotiation. Four use negotiation combined with budget review or formula. Seven programs use a combined method. Massachusetts and Pennsylvania use all three methods.

In five states regulatory authority is exercised by an appointed Commission (Connecticut, Maryland, Massachusetts, Oregon and Washington). In most other state-established programs it is exercised by a state department, usually assisted by some type of advisory group.

States differ regarding the categories of purchasers to which externally imposed rates apply. In most states they apply only to private insurers and payors. A critical issue has been whether Medicare and Medicaid programs would pay the same, usually higher, rates paid by other purchasers. Regulated rates apply to Medicare in only five states and Medicaid in eight states. Only in Connecticut, Rhode Island, South Carolina, and Washington do rates apply to both Medicare and Medicaid programs, and in these states rates apply to almost all payors or participating institutions.

Three states have programs that were established by state law but *do not require* the participating institution to accept program determinations. In Arizona the Department of Health Services reviews rates but individual institutions do not have to comply with the Director's findings, although they almost always do. In Oregon the Health Facilities Cost Review Commission may review the reasonableness of facility rates and, if it finds them excessive, may report its findings to the facility and the comprehensive health planning agency; in Wisconsin the decisions of the Hospital Rate Review Program are also advisory.

Indiana has the oldest rate regulatory system in existence, established in 1959. The program was not established by state law but participating payors (Blue Cross, private payors and insurers, and state agencies) are requested to comply with program decisions. The first state-mandated program was established by New York in 1970. Administered by the State Health Department, it regulates prospective Medicaid and Blue Cross rates by formula. Since 1971, when the California Commission was created by legislation, eight other states have established mandatory programs.

In 1973 the Reagan Administration proposed that CES controls and limited rate regulatory authority be given to the California Commission. This attempt failed and it was not until 1976, during the Brown administration, that the legislature acted to give CES authority to the Department of Health (DOH), implementing the National Health Planning and Resources Development Act, PL 93-641. Legislation sponsored by the Commission in 1975 to give it both rate regulation and CES controls also failed to pass. In 1977, Governor Brown recommended legislation to reorganize the Commission and give it rate regulatory powers, and this too failed passage. However, more modest measures to enlarge the Commission's role, sponsored by the hospital industry, were enacted. This section reviews efforts to expand the Commission's powers. It also briefly describes the history of 1976 legislation narrowing the scope of exemptions from these controls. This section generally illustrates the unwillingness of the legislature to enact regulatory programs that health providers find unacceptable. It also highlights the changing and sometimes divergent positions of health provider groups on proposed legislation in response to shifting cost-containment pressures.

According to Stigler, economic groups seek regulation that will benefit them by (1) providing subsidies; (2) controlling market entry; (3) controlling substitutes or promoting complements, and (4) fixing prices that will allow them more than competitive rates of return. However, Stigler also notes that regulation brings with

it certain costs, which he describes as (1) change in the distribution of industry control among firms; (2) administrative costs of the regulatory process; and (3) submission to political decisionmaking involving outsiders.

The position of California provider interest groups on rate regulation and CES controls illustrates the struggle within the health industry between proponents and opponents of expanded regulation. Proponents, primarily from nonprofit hospitals, believed that public-utility-like regulation would be in the economic interest of the hospital industry. It would promote economic soundness through a stable price structure and financing system, and permit the industry to participate in decisionmaking. In return the industry would submit to coordinated government controls over charges and capital expansion. Supporters feared that uncoordinated facility growth would prompt arbitrary government regulation unless the industry supported responsible regulation. Opponents (primarily physicians, investor-owned facilities, and Kaiser) viewed such controls as threats to their economic interests and were unwilling to risk submission to outside political controls. Physicians saw regulation of hospitals as only a step away from control over physicians' offices and fees under a system that might be dominated by hospitals.

The positions of some provider groups also reflect their support for economic controls that would limit market entry (restrict new construction) through Certificate of Need legislation.

SB 413: THE FIRST MAJOR EFFORT TO EXPAND THE COMMISSION'S ROLE

Initiation of SB 413

In 1973 the Reagan administration sponsored SB 413, a major effort to give control over health facility planning to the state, and authority to administer CES controls and regulate facility rates to the Commission. The Reagan administration, like its successor, faced the practical task of paying larger and larger health care bills through the state Medi-Cal programs, and favored controls over a

runaway health care system that many felt threatened the state's financial solvency. The Governor was convinced by his Health and Welfare Secretary, Dr. Earl Brian, that the state had to gain control of the health planning and regulatory apparatus to put a lid on this cost growth.

In his January 11, 1973, Annual Message to the Legislature, Governor Reagan said:

> We will offer new and far-reaching reforms:
>
> --To consolidate health facility licensing, hospital planning, and health cost review by eliminating overlapping and obsolete functions in these areas.
>
> --To bring about a better distribution of health care facilities through effective planning to insure that all our citizens have access to quality health care at a price they can afford.

A program to achieve these objectives was announced at a joint news conference by Health and Welfare Secretary Dr. Earl Brian and Senator Anthony Beilenson, Chairman of the Senate Health and Welfare Committee. The key features of the program were:

- o Consolidation into a unified health department of all facility licensing functions previously fragmented in separate state Public Health, Mental Hygiene, and Social Welfare Departments.[2]
- o Reorganization of areawide comprehensive planning agencies to improve health facility planning. Plans prepared by Regional Health Councils would be submitted to the Department of Health. The power to approve additional capacity by Certificate of Need would be transferred to the state.

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[2] Creation of a single Health Department was already mandated by a 1970 Governor's Reorganization Plan. It was not implemented until 1973.

- o Creation of a California Health Facilities Commission to (a) approve health facility construction and changes in license, bed care prices, and special services, (b) assume responsibility for administration of health facility functions of the Federal Economic Stabilization Program, and (c) assume the functions of the California Hospital Commission.
- o Improvement of quality of care standards and enforcement procedures in the Department of Health. The Department would license health facilities to provide basic and special services in hospitals and nursing home.

Brian was dissatisfied with the operation of local planning agencies and wanted to tie quality, quantity, and price together in an integrated facility planning system. He also believed that the state should contain costs by controlling cost per unit of service rather than by eliminating services, and felt a state regulatory body might accomplish this.[3] He contended that federal Medicare and Medicaid legislation had spurred inflationary pressures in the health care field that resulted in "uncoordinated hospital construction." He said local planning agencies

> . . . do not have the necessary authority they need to assure proper distribution of facilities, so we are now faced with the situation of having more hospital and nursing home beds in California than we can use. Another inflationary factor has been the constant addition of special care facilities and services [e.g., intensive care, renal dialysis, coronary care] often without regard to need. This has meant a costly duplication of services in some areas and an appalling lack of health care services in others.[4]

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[3] Interview with Health and Welfare Agency staff.

[4] Health and Welfare Agency Press Release, H & W 73-8, February 13, 1973.

Brian also anticipated that the administration of federal price controls would be delegated to the state and wanted a program ready for the purpose. In his view such regulation should be housed in a commission separate from the state's major purchaser of care.[5]

The administration asked Senator Beilenson to sponsor the legislation because he was chairman of the policy committee to which it would be referred and was considered to be a "strong author" with "integrity."[6] He had worked with the administration to help enact Welfare and Medi-Cal reforms and apparently was willing to work with the administration to get legislation he supported passed.

According to legislative staff, Senator Beilenson was primarily interested in quality of care improvement through changes in facility licensure and enforcement. The Senator's interest was partly based on the results of a California Medical Association peer review survey, which indicated that the state licensed and certified many poor-quality facilities. Several Los Angeles County physicians not associated with organized medicine complained to him that the inspection and quality control system for hospitals and nursing homes was totally ineffective. Beilenson wanted to introduce greater professionalism into the licensing and certification process.[7] In a press release announcing introduction of the administration-backed bill, Beilenson observed that "present licensing programs are concerned only with safety and sanitation, and give patients in health facilities no assurance at all that good quality care is being rendered."[8]

Problems With 314(B) Agencies and Quality of Care

According to DOH officials, legislators, legislative staff members, and industry spokesmen we interviewed, the system set up by 1969

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[5]Interview with Dr. Brian, October 6, 1976, and with Health and Welfare Agency staff.

[6]Interviews with Health and Welfare Agency staff.

[7]Interviews with Bill Barnaby, December 12, 1976, and Dr. Paul O'Rourke, April 21, 1977.

[8]Press Release, March 12, 1973.

legislation (AB 1340, Duffy, Chap. 1451), which established the powers and duties of nonprofit areawide planning agencies authorized to issue Certificates of Need and established pursuant to Sec.314(B) of PL 89-749, was not working effectively.[9] One DOH official said the planning agencies were "inconsistent, poorly administered, and beset with conflicts of interest."[10]

The former chairman of the Assembly Health Committee said, "The Duffy fill was politicized. Decisions were based on who knew whom and political clout. There was continued construction of unneeded beds and fights between locals and the state.[11]

A former Senate Health Committee consultant noted that "there was controversy about lack of accountability of regional agencies. Many felt they were self-appointed and anointed non-governmental regulatory bodies responsible to no one."[12]

Interviewees pointed out a number of problems in the law itself that made it ineffective. For one, a large loophole permitted "grandfathering" of facilities if hospitals submitted a plan or statement of intent to construct (perhaps consisting merely of an architectural drawing) by December 31, 1969. Furthermore, extensions of that deadline were permitted. Applications were denied only if opponents could prove that the applicant was not diligently pursuing construction--but "commencement of construction" was not defined, and

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[9]The State Comprehensive Health Planning Program in 1972 was organized into three planning levels: (1) the State Office of Comprehensive Health Planning in the Department of Public Health, set up under Sec. 314(a) of PL 89-749; (2) regional offices for the state's 13 regions, and (3) local comprehensive planning groups (the so-called "B" agencies) for 56 of the state's 58 counties. In addition, the State Health Planning Council, composed of providers, consumers, and public officials appointed by the Governor, was responsible for adoption of the State Plan for Health, hearing appeals and recommending allocation of federal facility construction funds.

[10]Interview with James Gentry, May 4, 1977.

[11]Interview with Senator William Campbell, March 22, 1977.

[12]Interview with Bill Barnaby.

in some cases one spadeful of dirt was turned to gain exemption from local review. In addition, hospitals could wait one year and then begin construction exempt from review. Rather than discourage hospital bed growth, many observers concluded that the law encouraged hospitals to construct early to escape from anticipated controls.[13]

The upshot, according to DOH officials, was that the rate of hospital bed construction between 1969 and 1972 was triple that of the preceding seven years, and the cost per bed was climbing. The supply of beds exceeded the need by more than 27,000, according to DOH calculations. Nursing home growth was also out of control. The number of homes more than doubled between 1966 and 1971, costs jumped, bed occupancy was down, and state requirements were exceeded by more than 20,000.[14]

Development of the Legislation

As first introduced in March 1973, SB 413 reconstituted the California Hospital Commission as the California Health Facilities Commission and placed it administratively in the Health and Welfare Agency. In addition to carrying out federal wage-price control administration if delegated to the states, the Commission also was mandated to:

- Develop a Health Facilities Economic Stabilization Program for establishment of rate levels that may be charged in California;
- Review and approve all new or additional health facility construction, all changes in licensure categories, all changes in bed categories, and all special services.

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[13] Interviews with Comprehensive Health Planning and legislative staff.

[14] Health and Welfare Agency News Release No. 59, April 25, 1973.

Areawide planning agencies would lose their authority to approve new hospital construction and would be reconstituted under guidelines of the state DOH, designated as the State Health Planning Agency under the federal Partnership for Health Act. Regional Council members would be appointed by the Governor and the legislature instead of being locally selected.

The Administration's "Marketing Plan"

It was anticipated that organized medicine, investor-owned hospitals, and areawide planning agencies would oppose many of the bill's provisions. Convinced that it would take a substantial effort to develop public support for it, the administration developed a strategy to gain passage of its program. A confidential memo describing how to "market" the California Health Facilities program detailed potential sources of support and opposition, and a timetable to mobilize support in the media, the legislature, interested groups, and state agencies. It contained a proposed schedule of news releases and broadcast appearances that might be made by administration spokesmen and identified newspapermen, broadcasters, staff of professional associations, legislators, and local government officials to be contacted to "sell" the program. It also contained an assessment of "key contacts" in the State Health Planning Council who might be helpful as program promoters.[15]

The fact that the memo was leaked to the press was a harbinger of how successful subsequent efforts to gain support might be.[16]

LEGISLATIVE ACTION ON SB 413

Part of the administration's strategy was to introduce sweeping legislation in anticipation that some compromises would be made with affected groups. Health and Welfare Secretary Dr. Brian initially felt he could get some form of the omnibus legislation enacted despite

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[15] *California Health Facilities Program*, undated.

[16] *Los Angeles Times*, January 10, 1973.

the opposition of health providers. According to interviewees on the CHA staff, Brian told the CHA he would sponsor the bill whether or not they supported it.

Since the bill appointed state funds, it would have to be heard by both Senate policy committees (Health and Welfare, and Finance). The legislation was the subject of hearings and amendments before the Senate Health and Welfare Committee for seven weeks in a row during April, May, and June 1973. It was highly controversial. Many negotiating sessions were held with interest groups to see if an acceptable compromise could be reached.

After compromise amendments were negotiated with hospitals and planning organizations, and after a major lobbying effort by the administration, the bill passed out of the Senate Health and Welfare Committee on a 7-6 vote over the opposition of Republican members and organized medicine. Most of the votes for it were from Democrats. However, provisions of the bill concerning planning, rate regulation, and Certificate of Need were excised before it went to the Senate Finance Committee as a facilities licensing bill.

Major opposition by organized medicine and local planning groups, and the inability to work out amendments acceptable to hospitals, convinced the administration that the political cost of getting the omnibus bill passed would be too high, since the major compromises necessary to get it passed would most likely result in a "weak bill."[17]

As finally enacted, SB 413 required surveys of facilities every two years and authorized a special permit process by the DOH for special services such as burn centers, radiation therapy departments, hemodialysis centers, and psychiatric units. Legislative intent was expressed that nonprofit organizations like CMA would continue to conduct inspection of facilities unless the DOH demonstrated they failed to comply with quality of care standards set by the act.

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[17] Interviews with CHA and Health and Welfare Agency staff.

Positions of Affected Organizations

California Hospital Association. The CHA favored delegation of economic controls to an independent state commission. CHA's policy on Delegation of Federal Economic Controls to the State of California, adopted January 11, 1973, set forth three principles governing that delegation: (1) Regulation should assure "due process, fair hearing, and reasonable guarantees protecting the maintenance and development of a viable hospital industry"; (2) policies should be administered by an independent statutory commission with price controls separated from other agencies and other major purchasers of health care; and (3) prospective rates should be determined in accord with AHA policy statements, and "should be equal for all patients receiving similar services, regardless of payment source." In accord with AHA policy, CHA also favored CES controls to limit facility growth.

Since Brian accepted these principles, CHA initially supported SB 413 *after* securing administration commitment to the principles.

CHA supported regulation by a single independent commission to replace present "uncoordinated and often conflicting" federal and state regulations. It also took the position that

> The supply of health facilities and services, the quality of care offered and the cost are interrelated. A single statewide authority to approve new construction is necessary to balance facility supply with expected demand . . . No industry likes to be controlled . . . But hospitals have taken the policy position that reasonable and fair regulations with due process . . . are preferable to the present inflationary pressures and uncoordinated efforts by government to control it.[18]

Some CHA leaders were not enamored with "killing" the "B" agencies and argued against an omnibus bill, suggesting instead that separate pieces of legislation be introduced to cover major elements of the program. CHA favored state control of Certificate of Need, however,

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[18]Hospital industry interviews.

on the grounds that the state might gain effective control over haphazard and inconsistent administration by local planning agencies.

When amendments were adopted that would have exempted Kaiser hospitals from provisions of the bill requiring Certificates of Need, CHA along with UHA opposed the bill.[19] They were unwilling to allow a segment of the industry with a large market share to be free of controls.

United Hospital Association. The UHA generally agreed with the proposed changes sought by CHA but also favored a separate commission to implement Certificate of Need responsibilities. It opposed the bill as concentrating too much power in the hands of one agency. UHA agreed, however, that language providing for the creation of separate advisory committees for these functions partially satisfied its concerns. UHA joined with CHA to oppose Kaiser-sponsored amendments.

Kaiser. Kaiser won exemption from the bill's Certificate of Need provisions, having argued that, because of their unique nature as a comprehensive group prepayment plan, they should be allowed to construct facilities to provide services to their members. Probably correctly, they viewed the support of other hospitals for planning controls as one means of stifling competition from Kaiser and rewarding inefficient health care systems.[20]

California Medical Association. The CMA was opposed to the overall purpose of the legislation and fought hard against it. It was against franchising and did not favor consolidation of such major functions as rate regulation and franchising, contending that it would concentrate too much power in the hands of the state and a single agency. It opposed application of the "public utility" concept to regulation of health facilities, state assumption of Certificate of Need authority, and state control of local planning agencies. It also opposed changes in licensure and regulation of quality of care by the DOH. After the bill was "gutted," provisions concerning Certificate

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[19] CHA statement on SB 413, June 13, 1973, before the Senate Committee on Health and Welfare.

[20] Hospital industry interviews.

of Need, rate regulation, and planning were excised. CMA supported compromise provisions requiring that all facilities be surveyed and permits for special services be issued by the DOH.

According to CMA, public utility regulation would result in low pay for hospital employees, making it difficult to attract qualified personnel. It would also inhibit future use of medical and technical advances and reduce the quality of care. They said disclosure should be given a chance to work to produce uniform data so that more effective programs might be developed.[21]

After amendments were adopted restoring some power to local planning agencies, subject to review by the Commission and exempting prepaid plans from Certificate of Need planning requirements, CMA continued to oppose SB 413 because "it would greatly confuse health planning," and would destroy local control over it.[22] CMA viewed regulation of hospital rates and capital expansion as only one step away from regulation of physician fees and office practice. Moreover, regulation of facility growth could place limits on physician access to use of technology and facilities, and place such controls in the hands of state bureaucrats and hospitals. Apparently, organized medicine was happier with the existing Certificate of Need system with its loopholes, and also probably exercised enough control over local planning bodies so that they were not considered a major threat to physicians' interests. It appears that the "quality of care" argument used by physicians to oppose regulation masks numerous other concerns. Their opposition is probably based just as much on protection of vested interests.

Regional Comprehensive Planning Organizations. The representatives of area comprehensive planning agencies, organized into the California Conference for Comprehensive Health Planning (CCHP) urged their local legislators to oppose SB 413 and testified against it.

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[21] CHA statement by Jean F. Crum, Hearings Regarding SB 413, Senate Committee on Health and Welfare, April 25, 1973. Employees in regulated industries earn more, not less, than prevailing wages in nonregulated industries.

[22] *Statement of Objectionable Features*, SB 413 as amended June 15, 1973.

They opposed state takeover of their planning and Certificate of Need functions. They correctly viewed the bill as an effort hatched by the administration and supported by hospitals to "do them in."[23] Lobbying by planning organizations in San Diego, Los Angeles, and San Francisco strongly influenced legislators from these areas on the Senate Finance Committee. At its first hearing, these agencies were represented by the newly organized California Conference for Comprehensive Health Planning (CCHP). They favored:

1. Review and approval of health facility applications by area CHP agencies under state-approved criteria.

2. Local selection of local area boards.

3. Use of state-approved locally developed health facility plans as a basis for decisions on health facility application.[24]

The CCHP averred that local agencies had done a good job of holding the line on unneeded construction. With some justification, they felt that the major problem was with the law itself. Nearly 82 percent of the almost 44,000 hospital and nursing home beds licensed or under construction in California since January 1970 were "grandfathered" under the law and not subject to local review. Despite this "loophole," local planning agencies argued that they had held the line on the proliferation of health facilities by more than 15,000 beds (or roughly 25 percent of what was possible), had discouraged applications for 12,668 beds, and had actually denied 2,408 beds. In their view they had done a good job getting organized under trying conditions, including confused and conflicting regulations emanating from federal and state agencies. They felt they had done much to improve, and that criticisms leveled at their early operations were no longer valid.

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[23] Interviews with hospital industry, legislative staff, and CCHP staff.

[24] Letter to Senator Beilenson from Brian Dobrow, April 26, 1973.

After amendments were negotiated with the administration and other groups, a spokesman for the CCHP said that a majority of "B" agencies supported the bill. The amendments significantly expanded local control by providing that:

1. Half of the members of regional councils would be appointed locally by boards of supervisors and the rest by local legislators and the Governor;

2. Planning bodies would not be "public agencies," permitting existing corporate local entities to operate;

3. Certificate of Need review and approval authority would be vested in regional councils.

The Commission, testifying at the request of Senator Beilenson, supported the intent of the bill although some Commission members opposed the creation of separate advisory committees for rate review and Certificate of Need. After it was pointed out that this provision was the result of a compromise with those who favored the establishment of two separate commissions, the Commission agreed not to raise this issue because it might hurt the bill's chances of passage.[26] The County Supervisors Association (CSAC) supported SB 413 after amendments providing that regional councils include appointees of local boards of supervisors.[27]

Analysis of Legislative Action

It is widely conceded that the primary reason for the defeat of SB 413 in its omnibus form was the combined opposition of organized medicine and local planning organizations, who effectively lobbied their local legislators in support of "local control."[28] Particularly

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[27]Letter to Senator Beilenson from CSAC, April 18, 1973. In a prepared statement presenting his bill, Beilenson said that amendments were negotiated.

[28]Statement to Senate Health and Welfare Committee by Mrs. Evelyn Reminger, representing CCHP, April 25, 1973.

successful efforts were launched in San Diego, Los Angeles, and San Francisco. In Los Angeles, the chairman of the local planning agency, a physician who was also speaker of CMA's House of Delegates, worked hard to defeat the proposal. In San Diego, petitions and letters were sent to local legislators. A Republican Senator from this area, John Stull, referred to the bill as a "rape of local controls" and tried to persuade the Governor not to support "this patently socialistic measure."[29] According to Senator Stull, Governor Reagan continued his support because of concern about low hospital occupancy and continued escalation of health care cost.[30]

Although Dr. Brian initiated SB 413, he did not personally manage legislative lobbying for it as he had for Medi-Cal reform, because of the pressure of his other duties.[31]

The bill was initially supported by CHA, but opposition by investor-owned hospitals and Kaiser weakened association support, and when Kaiser was exempted from facility planning regulation, CHA, along with UHA, openly opposed the program. This, along with powerful medical and local planning groups aligned against it, made negotiating a compromise doubtful if not impossible.

Some persons interviewed were surprised at the "grass roots" political effectiveness of local planning agencies, while others suggested that some of the opposition to the legislation was based on a "power grab" by Brian, placing greater authority in units of government that were subject to his control. A number of legislators, both Republicans and Democrats, wanted to "trim Brian's sails."[32] This, when added to provider and local planning group opposition, left the administration the lone supporter of its program.

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[29]Letter from Senator John Stull to Jean Crum, California Medical Association, May 10, 1973.

[30]Interview with Senator John Stull, March 28, 1977.

[31]Interview with Dr. Brian, October 6, 1976.

[32]Interviews with legislative staff, hospital industry and Department of Health.

Although Senator Beilenson carried the bill for the administration, he began to raise questions about the need for it after the opposition expressed at public hearings, and this probably helped influence the administration's decision not to push the omnibus program.[33]

Another contributing factor to the demise of SB 413 as an omnibus bill was confusion over the effect of federal regulations applying to "Certificate of Need" under Sec. 221 of PL 92-603. This section required the Designated Planning Agency (in California, the DOH) to approve all capital expenditures over $100,000. This conflicted with the provisions of SB 413, requiring still further amendments.[34]

The legislation passed the Senate Health and Welfare Committee only after heavy lobbying by the administration and over the objection of key Republicans. Administration strategists regarded some of the "yes" votes in Senate Health and Welfare as "shaky" and foresaw that it would be even tougher to get the bill out of the Senate Finance Committee, where greater industry influence was anticipated. Dr. Brian went to the Governor and told him the administration would have to give too much to get the bill passed, and the Governor went along with the recommendation that it be "gutted." Administration strategists probably assessed correctly the slim probability of getting a worthwhile program enacted, even with the Governor's support, and were unwilling to commit all their resources to a high-risk legislative battle.

In presenting his stripped-down bill before the Senate Finance Committee, Senator Beilenson said:

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[33]An indicator of this was a letter from Brian to Beilenson responding to the Senator's questioning of the need for some of the provisions of the bill. Brian argued that unfilled beds caused $2 million per day in unnecessary expenditures. Letter to Senator Beilenson, May 21, 1973.

[34]Letter to Senator Beilenson from Health and Welfare Secretary Brian, August 7, 1973.

> In the August 10 amended form before you, SB 413 is not the controversial bill it once was. Because of widespread confusion and recent changes in federal regulations, all former provisions in the bill dealing with health planning and rate review have been eliminated.[35]

And Dr. Brian, in retrospect, perceptively commented:

> One of the lessons to be learned from the SB 413 experience was the enormous difficulty of getting a coordinated planning and regulatory system for health facilities established. The entrenched interests won't let it happen, since their interest lies in keeping the system fragmented . . . In that way they could control it.[36]

THE AFTERMATH

After the demise of SB 413, and with the blessing of the administration, CHA sought to keep legislation alive that would provide for rate review and state control of the Certificate of Need process. These provisions of SB 413 were amended into other bills that still might be acted on in 1973. AB 2123 (Hayden) became the vehicle for rate regulation and AB 2477 (Waxman) for Certificate of Need.

CHA-sponsored amendments were made to AB 2123 giving the Hospital Commission responsibility to (1) assume federal wage-price controls for all institutional providers if this power were to be conferred on the states; (2) develop a Hospital Economic Stabilization Program "to retard inflationary costs and prices by health facilities in California" for submission to the legislature by July 1, 1975, after consulting with professional organizations; and (3) establish a uniform, comprehensive state system of accounting, reporting, and auditing for hospitals. (Commission implementation

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[35] Statement by Senator Beilenson in presenting SB 413 before the Senate Finance Committee (undated).

[36] Interview with Dr. Brian.

of this final responsibility is extensively discussed in Chap. 8 below.) It is important to note this legislation declared it to be state policy that hospitals are "affected with the public interest," a provision similar to the law establishing public utilities. It also charged the Commission with providing "reasonable and appropriate safeguards . . . that rates charged by hospitals are uniform for all purchasers of hospitals services."[37]

The CHA-sponsored legislation (AB 2123) was not opposed by any organized group, and after legislative enactment was signed by the Governor on October 1, 1973.[38] Interestingly, both the DOH and the Department of Finance supported this legislation despite its policy thrust toward nondiscriminatory rates which, if implemented, would add significantly to state costs. We speculate that this support reflects the administration's desire for state implementation of price controls and the fact that later Commission recommendations would have to be approved by both the legislature and the next gubernatorial administration, which would take office in 1975.

At the request of CHA and legislative staff, major Certificate of Need provisions were amended into AB 2477 (Waxman) under which the DOH (designated as the State Planning Agency), with the approval of the Commission, was authorized to develop rules for review of community need for health facilities. The Director of Health was required to approve a single state health plan for use by the Commission as a guide in reviewing applications for health facilities.

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[37]Under SB 413, the development of an economic stabilization program included all health facilities. However, to the chagrin of investor-owned nursing homes, the Hayden bill applied only to hospitals. This was changed by later legislation to apply to both types of facilities.

[38]Memoranda recommending the Governor sign the legislation were submitted by the DOH, September 25, 1973, and Department of Finance, September 28, 1973.

Applications for new facilities, conversion of existing facilities, and creation or expansion of new areas of service were required to be reviewed initially by local planning agencies, which forwarded their comments to the DOH. The DOH then issued findings and recommendations, which became the decision of the Commission unless the Commission ordered a hearing.[39]

The "B" agencies, however, along with organized medicine, opposed AB 2477 primarily because it removed Certificate of Need decisionmaking from local agencies. The CCHP said:

> The bill, in seeking to establish an "independent" commission, bypasses meaningful public and consumer participation, as now available through the 'B' agency system . . . The effect is to set up a small centralized commission structure which is subject to the vested interests it is supposed to regulate.[40]

During the following year, however, CCHP modified its position significantly to accept recommendation authority rather than decisionmaking authority in the Certificate of Need process.

Neither the hospitals nor Assemblyman Waxman decided to push this bill, and in August 1974 the planning and rate regulatory provisions were amended out of it. According to one hospital industry spokesman, "The fight over SB 413 had been so traumatic and caused so much confusion in the legislature, hospitals decided against going ahead at this time."[41]

THE STATE ECONOMIC STABILIZATION PROGRAM

After passage of AB 2123, both the Commission and the CHA almost immediately initiated efforts to meet its requirements for the development of a state-level Economic Stabilization Program. The Commission

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[39] Interviews with hospital industry and legislative staff. Legislative staff recommended that these provisions be amended into AB 2477 to preserve legislative option to act on Certificate of Need and rate regulation.

[40] CCHP comments on amendments to AB 2477, August 27, 1973.

[41] Hospital industry interviews.

conducted public hearings and deliberated for over a year before arriving at the recommendations contained in its Health Facilities Economic Stabilization Program report. Despite efforts of both the CHA and the Commission to develop the program, incentives for passing it were absent during the 1975 legislative session.

Three events influenced the development of the program and its reception by both the industry and state agencies. First was the expiration of wage-price controls on the hospital industry on April 30, 1974. Second was Governor Brown's election in November 1974. Third was the passage of the National Planning Resources and Development Act of 1974 (PL 93-641). The import of these events is discussed below.

The CHA Role

The CHA took the initiative immediately to prepare an economic stabilization program for submission to the Hospital Commission. A task force including nonprofit, Catholic, private, district, county, and Kaiser hospital representatives was established to develop a proposed position for the California hospital industry.[42]

The task force report was the product of 20 meetings over a seven-month period, staff work by CHA and professional consultants, and participation of representatives of various regional hospital councils. Its recommendations were based on the following general principles:

1. Increased government regulation of the health care system is inevitable. With national health insurance will come economic regulation. A foundation for such regulation at the state level must be developed.

2. Previous governmental regulatory efforts have been "frantic, irrational, and "piecemeal." Soon after Medicare and Medicaid went into effect, budgetary restrictions forced cutbacks in services and payments to providers. This was exemplified by tightened

[42]Gordon Cumming, CHA liaison with the Commission and its Director of Research and Advocacy, was designated as staff coordinator for the effort. Sam Tibbits and Isadore Weinstein were co-chairmen.

eligibility, greater screening of services and surveillance which came with 1971 Medi-Cal reform in California and federal planning legislation (PL 92-603) in 1972. Federal wage-price controls further expanded governmental regulation.

3. Regulatory programs must be rationalized by integration of planning, Certificate of Need, and licensing.

4. A fair payment system should be established for meeting institutional health needs within attainable financial resources. "A basic principle in this program is . . . equal resources . . . payment for all services in each institution for all purchasers, including government."[43]

The task force recommended that the California Hospital Commission be reorganized and its powers and duties extended to:

- Include all health facilities;
- Implement budget rate review;
- Develop "effectiveness standards";
- Issue Certificates of Need for new construction and major changes in services or equipment based upon review and recommendation of appropriate planning agencies;
- Approve and adopt the health facilities portion of the State Plan for Health;
- Establish "standards of community demand or need" for health facility services to serve as advance criteria for budget and rate review;
- Serve as the Designated Planning Agency under federal law (PL 92-603);
- Approve and adopt health facility licensing regulations developed and administered by the Health Department.

Under the proposed system, prospective rates would be approved for each institution after submission and review of facility budgets. These budgets would be based upon regulatory guidelines governing

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[43] Summarized from *Effective Health Facility Regulation for California: A Report to California Hospital Association's Board of Trustees*, CHA, 1974.

both overall rate increases and specific budgetary components (salaries and fees, utilization, wages, etc.). In establishing guidelines the Commission would balance community need, quality, and utilization levels. The budgets would be screened against the guidelines, monitored with respect to costs, and subjected to "desk audit" for completeness, accuracy, and compliance by Commission staff. About 15 percent of the budgets would be subject to detailed annual review. The establishment of prospective rates would depend upon operating costs, teaching and research costs, and other financial needs including working capital, capital needs, reasonable return for investor-owned facilities, interest, taxes, and licenses.[44]

Subsequent to its presentation to the CHA Board of Trustees on May 16, 1974, the Task Force Report was the subject of major discussion and review within the health industry at numerous area meetings in which over 500 hospital representatives participated. It was also reviewed by the UHA, CMA, the DOH, State Advisory Health Council, local planning agencies, the CAHF and other interested organizations.[45] Apparently, CHA and CMA leadership wanted to avoid the open split between provider groups that had occurred on SB 413, and sought to develop a negotiated compromise program acceptable to major segments of the health industry.

The CMA recommended that the task force report be modified to separate planning and standards authority from the Health Facilities Commission and place it with the Advisory Health Council, and to exclude physicians and other health practitioners' offices from Certificate of Need requirements.[46] A primary CMA motivation was to limit and fragment regulatory authority.

The UHA suggested that an independent commission be set up to administer Certificate of Need requirements and act as the Designated Planning Agency, and favored exempting replacement beds from Certificate

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[44]Ibid.

[45]Minutes of CHA Board of Trustees Meeting, May 16 and 17, 1974.

[46]Ibid., August 20, 1974.

of Need requirements. It also proposed that budgets for existing facilities and those under construction be included as meeting community needs and that "reasonable unbudgeted surpluses be maintained by facilities and not used to offset full financial requirements in the future."[47] UHA favored the inclusion of major "loopholes" that would limit negative regulatory impact on investor-owned facilities.

After hearing the objections of these groups, the CHA Trustees' Executive Committee recommended that the proposed CHA Policy Statement on Governmental Regulation be modified to provide that Certificate of Need and Designated Planning Agency functions be withdrawn from the Commission and delegated to the Advisory Health Council (renamed the Health Council). Several Board members opposed separation of planning and rate review responsibilities, and others were concerned about inadequate provision for accumulation of surplus funds for nonprofit hospitals. The modifications were accepted to gain UHA, CMA, and other group support for overall Task Force recommendations. With these changes CMA agreed to support the Task Force report in principle *and to join CHA in seeking implementing legislation*. The modified Association policy was presented by CHA to the Hospital Commission.[48]

The CHA made further changes in its policy position during early 1975 as the Commission was developing its own recommendations. In a January 1975 statement before the Commission, the CHA proposed that a new independent 7-member board (4 public and 3 industry), attached administratively (for housekeeping and staffing functions) to the DOH, be created to issue Certificates of Need rather than the Advisory Health Council. The CHA proposal was partly based on the CHA view that the intent of federal planning legislation (PL 93-641) was to link facility planning and Certificate of Need with the functions of the designated planning agency (DPA). In their view it was impractical to consider that any state agency other than the DOH could qualify as the DPA.

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[47] Ibid.

[48] Ibid.

During 1975 CHA declined to sponsor its own rate review legislation, nor did it support Commission-sponsored legislation.

The Commission Role

The Commission participated in deliberations of the CHA task force and in January and February 1974 held a series of five public fact-finding hearings on the financial regulation of hospitals. The Commission appointed its own Rate Review Proposal Subcommittee, which worked from April through July 1974 to develop recommendations to the Commission. The Commission then submitted its final report to the legislature in March 1975. The highlights of the Commission's work are described below.

Commission Hearings. At the Commission's early 1974 hearings, CHA supported the development of a permanent state-level economic control program to replace the federal price control system.[49]

The UHA, after reviewing of rate controls in other states, concluded they had not worked. UHA's view was that any economic stabilization program mandated by the legislature should be administered by a full-time independent body separate from any state agency regulating Certificate of Need and advised by technical experts from industry. UHA favored (1) budget and rate review and approval, and prospective payment based on negotiations, hearings, and due process including "de novo" judicial review; (2) equal payment for all purchasers; (3) state approval of any third-party payor discount based upon justification, and (4) inclusion of prepaid plans and surgicenters in any regulatory program.[50]

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[49] Statement to the Commission by Arthur Jost, President of CHA, January 8, 1974.

[50] Statement by Max Weinberg of UHA, January 8, 1974. De novo judicial review consists of a review of the entire disputed matter, not just a review of the administrative record. Because frequent court reviews could well stymie the administrative process, the existence of such a procedure would tend to make regulators wary of making decisions aggrieved parties would take to court.

The CMA position was essentially the same as stated to the CHA Task Force: that rate setting and quality of care regulation should be separate, and that payment controls should not downgrade quality.[51]

Kaiser continued to oppose rate regulation, arguing that in other regulated industries such controls have been used to halt or retard innovations. Furthermore, Kaiser argued, there is no evidence that hospital costs are grossly unreasonable, that hospitals are making large profits, or that cost barriers are preventing people from getting care. Kaiser also questioned whether state and federal governments would accept Commission rates. They argued that if regulation were to be imposed, (1) there should be adequate provision for capital generation (which, in their view, was not adequately provided by Medicare); (2) hospital revenues received by prepaid group plans from its members should be exempt because regulation of HMO hospital charges, like fee-for service hospitals, would be inappropriate and "highly detrimental to the development of organized health care systems," and (3) it should be on rates charged to subscribers by the HMO and third-party payors such as Blue Cross, Blue Shield, and private insurers.[52] Kaiser favored exemption of prepaid group plans from CES controls. A new element in Kaiser's position was their suggestion that, instead of exemption, Kaiser be allowed to expand if beds it needed were unavailable under suitable conditions in the community.

The DOH spokesman urged that the Commission and the DOH cooperate in developing a cost containment program. He recommended that (1) the state enact a single uniform capital expenditure program applicable to all facilities; (2) rate setting and capital expenditure reviews be separated, "lest one become all controlling as the cost containment mechanism," and (3) planning agency decisions be binding on the rate-setting body. In the Department's view "rates charged for a

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[51] Statement by Dr. Thomas Elmendorf of CMA, January 8, 1974.

[52] Statement by Robert Erickson, January 23, 1974.

service should not become the overriding factor in determining whether a service should or should not be provided in a given community." Moreover, according to the DOH, if construction receives planning approval, then the cost to support that decision must be borne in the rate and accepted by the rate review mechanism. The need for the facility should not be redetermined by a rate-setting body.[53] The Department wanted to control the Certificate of Need process and was willing to let the Commission regulate rates, but under conditions that gave the Commission limited discretion.

The CCHP representatives stressed the need for interrelating planning and rate setting to attain a good facility utilization, but made no specific recommendations. They also stressed the need to rely on community planning, which could contain costs by discouraging duplication of services.[54]

A spokesman for the Western Conference of Teamsters favored the imposition of price controls administered by a board "perhaps similar to the Public Utilities Commission," with the outstanding exception that it be made up largely of health consumers. He also supported prospective budgeting as providing incentives to contain costs.[55]

Blue Cross representatives favored state over federal rate regulation, but stressed that the federal government would most likely not pay for costs not associated with the population they cover (e.g., bad debts for nonfederally subsidized patients) and would "most likely not accept a uniform rate determined by the state." They favored a flexible rate-setting approach so as not to discourage promising changes in the delivery system, such as the development of Health Maintenance Organizations (HMOs). They argued that a fixed single

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[53]Statement by Robert Jackson of DOH, February 6, 1974.

[54]Statement by Mary Helen Abbey, Vice President, Comprehensive Health Planning Association of Imperial, Riverside, and San Diego Counties, February 6, 1974.

[55]Statement by Robert Beadle, Business Agent, Western Conference of Teamsters, February 6, 1974.

rate structure is "not the vehicle that can accommodate change" and favored negotiated prospective payment and a "class of purchaser arrangement . . . based on the underlying costs applicable to the class of patient." One effect of uniform rates would be elimination of the small discount given Blue Cross by Southern California hospitals. They also supported cost-based reimbursement controls, "despite their weaknesses," as "better than arbitrary rate-setting" and suggested that a profit margin be built into the formula that would apply to both profit and nonprofit hospitals.[56]

Blue Shield supported equal rates for similar services by all payors, but suggested that "great care must be taken that any rate equalization does not descend to the lowest level currently paid." They also supported experimentation with prospective payment on a voluntary basis by hospitals in a given area and the involvement of the physician in periodic examination of services and charges.[57]

The Health Insurance Association of America favored a single method of reimbursement that would "eliminate a favored position for any one or more sources of reimbursement" (e.g., Blue Cross plans). One obvious effect of this would be to improve their competitive position. They supported flexibility for rate changes when effective utilization resulted in reduction of income. They argued that if occupancy continues to be reduced, "the institution should be required to develop plans for converting the surplus to other currently unmet community needs, such as ambulatory care, surgi-centers, and skilled nursing facilities."[58]

The SSA representative described the experience of federally supported experimental and demonstration projects in the field of prospective reimbursement. In his opinion, "It seems to make more

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[56]Statements by William Warhurst, Blue Cross of Northern California and James Brown, Blue Cross of Southern California, January 23, 1974.

[57]Statement by Helen Ogelsby, Blue Shield of California, January 23, 1974.

[58]Statement by C. Donald Hankin, Health Insurance Association of America, January 23, 1974.

sense to go to a formula rate-setting approach . . . It looks more complicated but it tends to be more exacting than working a budget approval system." He suggested that if there were a state-mandated program Medicare would pay the same rate as other purchasers, "but I'm not really sure."[59]

CAHF's representative urged the Commission to support legislation that would include nursing homes in their economic stabilization study, and supported (1) Commission assumption of Certificate of Need authority but no controls over existing facilities and services; (2) rate regulation guaranteeing facility costs including profit; (3) rate differentials based upon differences in service and quality; (4) prospective payment including adjustments due to cost of living, and (5) equal payment for equal services by all purchasers.[60]

Rate Review Subcommittee. The Commission appointed a Rate Review Proposal Subcommittee. It examined programs in other states; analyzed the likely effect of prospective payment; reviewed alternative rate regulatory approaches; and considered ways to structure a state cost containment program involving both rate review and capital expenditures controls.[61] It made recommendations in July after the CHA Task Force report had been received.[62] Materials prepared for the subcommittee suggested that in return for stable financing, the hospital industry would accept increased government regulation aimed at improved efficiency.[63]

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[59]Statement of Ronald Carlson, SSA, January 23, 1974.

[60]Statement by Henry C. Heil, Jr., President of CAHF, January 8, 1974.

[61]The subcommittee members were W. Norman West (Hospital Financial Management Association, James Brown (Blue Cross, South), Charles K. Bradford (UHA), Gordon Cumming (CHA), Dr. Gladden V. Elliott (AMA), Dr. John Mitchell (California Regional Medical Program), Helen Ogelsby (Blue Shield), Douglas Swinnerton (Health Insurance), William Warhurst (Blue Cross, North) replaced by Lew Rivera, Arthur Rosenfeld (Kaiser), and Brian Dobrow (CCHP). The subcommittee recommendations were received in August 1974.

[62]Commission Minutes July 11, 1974. See also Agenda materials for Subcommittee meetings April 15, May 1 and 2, June 12, 13, 27 and July 11 and 12, 1974.

[63]Subcommittee agenda materials for July 12 and 13, 1974 meeting.

Several subcommittee members favored separation of rate regulatory and Certificate of Need functions to avoid concentrating too much power in a single group administering a consolidated program. However, the Commission favored administration of these functions by a single agency; its opinion was influenced by its role as State Advisory Board under the federal economic stabilization program. Under that program, the commonest justification given in requesting exceptions from price control was the need to pay for capital expansion. Commission members believed they could not be held accountable for cost increases unless they made Certificate of Need decisions.[64]

The Subcommittee recommendations and those of the CHA Task Force became the basis for deliberations by the Commission and its Advisory Council and the response of interested organizations. Five drafts of the Commission's report were also the subject of public comments between November 1974 and March 1975.

The Commission Report

The Economic Stabilization Report submitted four recommendations to the legislature, to be implemented by expanding the Commission's power and duties:

1. Increased public disclosure of health facility budgets and charges . . .

2. Budget and rate review and approval to be implemented *when federal and state governments agree to pay providers of health facility services on a fair basis which does not shift costs from one provider to another.* [Emphasis added]

3. Regulation of health facility capital expenditures.

4. Economic Impact Analysis of proposed state legislation, department regulations and local planning.[65]

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[64]Commission minutes, August 28, 1974.

[65]*Report to the California Legislature for Health Facilities Economic Stabilization Program*, California Hospital Commission, March 1975.

Rate regulation and capital expenditure controls would be administered by a 13-member Commission (as reconstituted by AB 4396 with 7 public members) with the assistance of two separate 12-member part-time technical review boards: a Budget and Rate Review Board, and a Certificate of Need Board. The boards would advise the Commission on issues, regulations, and guidelines. The representation on the technical review boards was heavily weighted toward providers.[66]

The proposal for increased public disclosure would require filing of annual summary budgets and selected rates as defined by regulation for publication by the Commission. The Commission would grant a Certificate of Need for either new facilities and services, or for replacement, conversion, or reduction of existing facilities and services, "in accordance with its own regulations which must be consistent with those of the State Designated Planning Agency" (DPA). The DPA would have responsibility for the State Plan for Health based upon "economic impact analysis criteria" developed by the Commission. These criteria or guidelines would concern building programs, budgets, and rates.

The most controversial Commission recommendation was that Certificate of Need be combined with budget and rate review and approval in the same agency, even though administered with the assistance of separate technical boards. This was opposed by CMA, CHA, UHA, Kaiser, and area planning organizations.[67] The Commission was convinced that consolidation of rate regulation and capital expenditure controls was a necessary element to any effective regulatory program "because of the significant effect of capital

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[66]Each board would include 8 providers (3 physicians, 4 facility representatives, and 1 prepaid group plan member); 2 third-party purchasers (1 commercial insurance, 1 service plan); and one government purchaser, plus the Commission Chairman.

[67]See, e.g., CHA Statement to the California Hospital Commission, January 22, 1975.

expenditure on costs." It noted: "To do otherwise would create a confusing entanglement of responsibility with multiple interaction between various regulatory bodies which would undermine public accountability and control."[68]

Also controversial were the Commission recommendations concerning capital expenditure controls, which were supported by CHA but opposed by UHA. UHA in 1974 had successfully obtained passage of legislation that exempted, from areawide Certificate of Need review, the remodeling or replacement of existing facilities not involving increases in beds or changes in license category. The Commission's recommendations would negate the provisions of this law.[69] UHA also opposed the application of Certificate of Need requirements to reduction of bed capacity or services.

Although the Commission's recommendations failed to exempt Kaiser, their report did include language requested by Kaiser indicating that a Certificate of Need should be granted for Kaiser-type facilities "when they are not available from existing facilities in a manner which is consistent with the basic operation of a hospital-based direct service group practice prepayment program."[70] Kaiser also urged, unsuccessfully, that revenue received from its members should be exempt from budget and rate review since its hospitals do not operate on the basis of billed charges.[71]

CAHF supported the Commission's assumption of Certificate of Need but shared UHA's position that this not be required for replacement modernization of existing facilities, or reduction of services.[72]

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[68] Commission Report, p. 3.

[69] SB 1883, sponsored by Senator Song. See UHA Statement to the Commission, January 27, 1975.

[70] Ibid. Kaiser has purchased hospitals in Martinez and San Jose, California, rather than build its own facilities in these areas. It also uses non-Kaiser hospitals on a routine basis in Colorado and Hawaii, and for specialized services in all regions.

[71] Kaiser Statement to the Commission, November 20, 1974.

[72] Letter to Commission from Robert J. Gerst on behalf of CAHF, December 17, 1974.

The CHA and the Commission's Economic Stabilization Program both recommended the establishment of a budget and rate review and approval process to meet hospital financial requirements, but did not specify criteria and guidelines. In general it appears that the primary industry objectives were (1) to assure that regulation would not reduce quality; (2) that hospitals would receive equal payment for the same service by all purchasers; (3) that hospital financial requirements, including rate of return or surplus, would be met, and (4) that the continued existence of the hospital industry would be assured. In return for these guarantees industry was willing to accept increased government regulation.

The Commission chose to recommend a budget review rather than a formula approach to rate setting, according to its former Chairperson, because "the formula approach has been tried in other states and it just doesn't work. It is too simplistic, and doesn't adequately account for differences between hospitals."[73] There was no public opposition to the concept of equal payment for all purchasers even though State costs would soar if Medi-Cal were required to pay the same rate as private purchasers.

LEGISLATIVE ACTION, 1975-1976

In spite of the Commission's arduous labor in developing an economic stabilization program, the environment for its adoption was unfavorable. When Senator Beilenson introduced it (SB 1107) on April 22, 1975, it received a cool reception. The new Brown administration did not support it or the Commission (see Chaps. 8 and 10). The hospital industry neither backed the Commission's program nor introduced its own. According to hospital industry observers interviewed, after price controls were lifted in April 1974 the industry backed away from supporting any rate regulatory program and went back to business as usual, despite CHA's 1974 position that it would seek legislation

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[73] Interview with Phyllis Smith, February 17, 1977.

implementing its 1974 policy on government regulation. According to these observers, experience with federal controls and Medicare reimbursement cutbacks dampened industry support for such regulation. Moreover, it was argued, why should the industry foist unpredictable controls on itself when the Brown administration was not even pushing for them? Also, since the future role and composition of the Commission were in doubt, it might be better not to launch any initiatives and adopt a "wait and see" posture. The author of the Commission's bill did not push it, apparently because it had no administration support and he questioned expanding the role of a body primarily influenced by health providers. SB 1107 was never even set for Committee hearing.[74]

The legislature, working with the new administration, focused on implementing the National Planning Resources and Development Act, which required that states designate planning agencies and institute a Certificate of Need program within four years. It mandated creation of health system agencies (HSAs) to serve health system areas and develop health system plans. These HSAs were to review and make recommendations on the need for additional facilities and services under a Certificate of Need program administered by the state. The act also called for creation of a State Health Coordinating Council (SHCC) to prepare a State Health Plan and review activities of area agencies.

The legislature enacted implementing legislation in 1976 and Governor Brown promptly labeled it as "weak," primarily because of the replacement provision "loophole." This legislation had important implications for the Commission. On the one hand, it resulted in delegation of CES controls to the Commission's major competitor, the DOH. On the other hand, the administration's handling of the bill stimulated legislators' antipathy toward the DOH and their willingness

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[74]Interviews with Assemblyman Keene, April 12, 1977, and health industry.

to work with the Commission or at least tolerate its continued existence. (The history of 1975 and 1976 legislative actions is described in greater detail below.)

After the change in gubernatorial administration, the Chairman of the Assembly Health Committee in 1975 chose not to introduce the Commission's program; he was looking toward the new Democratic administration to take leadership. He felt they would be "competent" and "consumer-oriented" and he had some concerns about industry influence over the Commission.[75]

The first effort to implement PL 93-641 was AB 1149 (Keene), an early attempt to establish the DOH as the Designated Planning Agency and require state approval of capital expenditures over $150,000. When the malpractice crisis hit in 1975, the Governor included health planning on the special session agenda and AB 2 was introduced in essentially the same form as AB 1149.

The legislature vacillated about which agency should administer rate regulation. AB 2, as introduced, gave the Commission responsibility to "implement a system to retard inflationary increases in the rates charged by institutional providers."[76] The bill was soon amended to give this responsibility to the DOH and in subsequent amendments rate regulatory language disappeared altogether.[77] The legislature had its hands full with Certificate of Need and preferred not to tackle rate regulation at all during the 1975-76 session.[78]

Positions of Organizations

The Assembly Health Committee held hearings in the fall of 1975 to look into the reasons for rising hospital costs and ways to contain

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[75] Interview with Assemblyman Keene, March 23, 1977.

[76] AB 2, May 19, 1975 version, Sec. 442.11.

[77] AB 2, as amended May 23 and June 18, 1975.

[78] Interviews with hospital industry and legislative staff.

them. One of its objectives was to compare the approaches of AB 2 developed by the Assembly and SB 1107, the Commission's proposed legislation. The committee examined defects in existing planning laws and heard the positions of interested organizations, summarized below.

Department of Health. The DOH contended that the state should set hospital rates and develop a Certificate of Need program, and that the DOH should administer both, because it would be more independent of the industry and already had planning and rate regulation responsibilities under Medi-Cal.

DOH representatives attributed most cost increases to inefficiency, duplication of services, and excessive construction, and contended that retrospective cost reimbursement systems provided no incentives to economize. DOH officials testified that hospital rate increases were substantially reduced under federal price controls, but that after these controls were removed rates of growth resumed their upward inflation, rising at 15 percent a year since May 1975. In their view, rate setting should be coordinated with licensing standards and facility planning activities then under way in the DOH. They favored a Certificate of Need law that not only would apply to new facilities and services but also would include powers to delicense inefficient or low-occupancy facilities and approve interchange of bed categories and modernization of facilities and services.

The DOH also favored prospective payment to encourage hospital efficiency and indicated it would use rate setting to force consolidation of services by disallowing Medi-Cal payment to certain underutilized institutions.

The Commission. The Commission countered that it should have Certificate of Need and rate regulatory authority because it was a public decisionmaking body and not the major purchaser of care. The Commission supported the recommendations of its economic stabilization program report.

Robert Derzon, then a member of the Commission's Advisory Council, stressed the need to link economic control and Certificate of Need

because "surplus capacity and resource input . . . are so fundamental to the cost of health care that these two devices have to be put together."[79] He believed criticism of industry domination could be surmounted by having public members predominate on the Commission. He opposed rate regulation on the grounds that no evidence had as yet shown it to be successful. He favored amplification of disclosure and regulation of rate of return and surplus accumulation.

CHA. The CHA supported a "strong" Certificate of Need function in the DOH with an independent appeals board to handle disagreements. Since these would be rare, the CHA position saw no need for a Commission to pass on every application, and argued that Certificate of Need should be administered by the same agency concerned with quality standards and licensure.

CHA's position on rate regulation was that this should come later, *after* disclosure, and that any future rate regulatory system should adhere to previously stated CHA policies (i.e., separation of regulator and purchaser, equal payment, and budget and rate review of individual facilities).[80]

UHA. UHA continued to favor an exemption for modernization or replacement of existing facilities and services in any Certificate of Need law, and opposed giving the relevant authority to the DOH because its fiscal responsibilities would prevent it from making impartial decisions. However, in a departure from its previous position before the Commission, UHA also noted that if this authority were after all given to the DOH, UHA could support it only if an independent appeals board were constituted and if aggrieved parties were empowered to seek "de novo" judicial review by the courts. The system would also have to provide for a hearing process to settle disputes.

UHA opposed rate-setting as administered in existing programs as taking the form of artificial ceilings and as being restrictive,

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[79] Assembly Hearings, p. 66. Derzon spoke as an individual and not as a representative of the Commission.

[80] Testimony by CHA President William Whelan, Assembly Hearings, p. 180.

confiscatory, and arbitrary. UHA continued "reluctantly" to support a rate review process administered by an independent Commission established under conditions previously stated before the Commission. They also suggested that there be two or more prospective payment mechanisms from which providers could choose on an annual basis, and that these be tested on a pilot basis before full implementation.[81]

Kaiser. As it had previously done before the Commission, Kaiser continued to press for a special provision allowing it to expand when other beds were unavailable. Kaiser representatives indicated that special provisions had been inserted into PL 93-641 which recognized "that special consideration and criteria" had to be applied to health maintenance organizations like Kaiser in the Certificate of Need process.[82] Under the state's existing application of State Plan for Health criteria, Kaiser officials maintained there would be no expansion of Kaiser Foundation hospitals. This would limit the choice of people to join Kaiser, which provides a relatively efficient delivery system.

CAHF. The CAHF altered its previous support for Certificate of Need controls in the Commission. It now supported CES controls in the DOH, but urged that rate review "be assigned to an independent unbiased agency or commission such as the Health Facilities Commission." It also favored a separate body such as the Commission to administer Certificate of Need appeals. CAHF favored exemptions of replacement facilities from Certificate of Need requirements.[83]

CAHA. The CAHA requested that Certificate of Need legislation provide special consideration for programs that serve special populations. According to CAHA, nonprofit homes had difficulty in developing

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[81]Assembly Hearings, Statement by Carl Weissburg, pp. 219-229.

[82]Hearings, testimony by James Lane, p. 146. He referred to Secs. 1502, 1602, and 1532(c) of PL 93-641.

[83]Hearings, Statement by Dennis Waggoner, pp. 146-156.

retirement centers that provide a relatively small number of nursing home beds to serve their internal population, because they had to go through a Certificate of Need process that based a decision on the availability of other beds in the community.[84] These facilities provide continuing care for retirees on a contract basis. According to CAHA, planning formulas based on community need violate these contracts.

CCHP. The CCHP continued to criticize loopholes in the Certificate of Need law allowing facilities to be constructed one year after having been denied a certificate and "grandfathering" existing facilities. They also criticized (1) variable interpretations by the DOH permitting conversion of long-term care beds to acute care; (2) overbedding, saying California had 22,000 more acute beds than needed; (3) competition by hospitals resulting in duplication of equipment and services; and (4) the building of small, inefficient community hospitals. They favored delegating Certificate of Need authority to the DOH, with local health system agency (HSA) review and comment and public hearing. CCHP favored granting Certificates only to fulfill community need as determined by local planning bodies. Their position was that projects requiring such a certificate include new facilities, increases in bed capacity or reclassification, conversion or modernization, and changes in services including diagnostic nuclear medicine, renal transplant, and cardiac catherization. CCHP also favored prospective payment and rate review coordinated by the DOH, the Commission, and HSAs "as desirable but not an imperative for action today."[85]

Consumer Health Coalition. The Consumer Health Coalition testified that PL 93-641 was a weak law, and the state should go beyond its provisions by requiring that HSAs review hospital admissions and discharges, and that hospitals use efficient procedures as a condition

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[84] Hearings, Statement by Steven Garner, representing CAHA, p. 163.

[85] Assembly Hearings, pp. 213-217.

of licensure. The coalition favored power to close hospitals and to review all expansion. It also favored the establishment of a paid public member Commission to administer Certificate of Need and rate review rather than the DOH, because "the bureaucrats have done a lousy job and keep making decisions that favor the industry." The Commissioners would be appointed for one-year terms and restricted for ten years from becoming affiliated with the hospital industry.[86] Apparently, the coalition failed to perceive that one-year terms could well procreate a Commission consisting of public members with good intentions who had so little time to learn about the hospital industry that they would be likely either to make bad decisions or be forced to rely on industry advice.

Summary

In sum, most groups that testified before the Assembly Health Committee favored or would accept CES controls in the DOH but disagreed on the extent of regulation over existing, as opposed to new, facilities and services. CHA supported legislation reposing Certificate of Need authority in the DOH. UHA and CAHF favored a Commission but would support Certificate of Need in the DOH if there were an independent appeals body and due process protection. Kaiser was more concerned about gaining exemption from controls than about where controls would be lodged. Area planning agencies accepted final Certificate of Need authority being given to DOH, with opportunity for local HSA review and comment. CCHP also favored tightening up provisions of previous planning laws.

The DOH wanted both rate regulatory and Certificate of Need controls, but was strongly opposed by the hospital industry and planning organizations. The legislature decided not to consider rate regulation during the 1975-76 session.

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[86] Ibid., Statement by Douglas Engmann, pp. 86-100.

LEGISLATIVE ACTION ON CERTIFICATE OF NEED

The Commission had little support in the legislature during 1975 and 1976 and even less from the administration. Most legislative staff active in the health field viewed it as being too close to the industry and still influenced by the Reagan administration.[87]

The legislature chose to work with the new administration and the DOH, rather than the Commission, on Certificate of Need legislation, but relations between the two branches of government on health matters soon began to show signs of strain. According to one legislative source, the administration did not want to work with hospitals on the development of Certificate of Need legislation and was disturbed by Keene's effort to negotiate with them on AB 1149 and AB 2. In Keene's view, negotiation with hospitals was essential to assure passage of this important legislation. After Keene negotiated amendments with the industry, the administration opposed the bill. Hospitals then also worked against it, thus assuring its defeat in the Assembly Ways and Means Committee.

The administration and the Assembly Health Committee worked jointly to develop an acceptable Certificate of Need bill. Two measures resulted that were introduced in 1976. AB 4000 designated the DOH as the State Planning and Development Agency and prohibited new construction, additional capital expenditure over $150,000, conversion of bed capacity, or modernization of facilities without Certificate of Need approval from the DOH. It also authorized establishment of area health system agencies, a State Health

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[87] Interviews with legislative staff. Symbolic of the influence of the past administration was the Commission's decision in 1975 to hire an aide to former Health and Welfare Secretary Earl Brian as one of their Executive staff. The Commission and the industry also resisted legislative efforts to remove the Title 18 exemption from the Disclosure Act.

Senator Beilenson introduced SB 2162 in April 1976, which reconstituted the Commission to make it a 7-member body with all appointees to be "public members." This was supported by the Commission Chairperson but not by industry members. This action by industry members reinforced the view that the Commission was industry dominated. Under this bill the Commission would act as an appeals board for Certificate of Need decisions. Beilenson felt that interested parties should not be making final decisions on Certificates of Need "any more than you have members on the courts that decide on appeal."

Coordinating Council and a Certificate of Need Appeals Board. AB 4001 was aimed at correcting existing deficiencies in the planning law and was introduced primarily to provide emergency funds for the "B" agencies during their transition to becoming health system agencies.

AB 4001

According to persons interviewed, the DOH was poorly prepared to defend AB 4000. It could not respond convincingly to industry questioning about what was necessary to implement PL 93-641, and its presentations were generally picked apart by the industry before legislative committees, to the point where Keene's AB 4001 became the key vehicle for implementing Certificate of Need regulation.[88]

In contrast, the hospitals presented a "united front" and were "well represented." Each hospital constituency championed amendments to the bill. Investor-owned facilities wanted exemptions of replacement facilities. Kaiser favored exemption for prepaid group plans. Catholic hospitals supported certification of beds to meet the needs of religious groups. The major point of contention was exemption of replacement facilities for 10 years, which investor-owned hospitals were able to get amended into AB 4001 in the Assembly Ways and Means Committee. Keene reluctantly accepted this amendment to "keep the bill moving" in the legislative process, hoping that "toughening" amendments would be inserted in the Senate.

Assemblyman Keene and Senator Beilenson worked together to stimulate pressure in the Senate for "a tough bill" and removal of the "replacement" and other industry-sponsored amendments. Senator Beilenson had sponsored legislation (SB 1378) that would impose a two-year moratorium on all facility construction. The Keene-Beilenson strategy was to use the possible passage of a moratorium bill--less acceptable to the

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[88]The Department spokesman at one point infuriated the hospitals and almost upset the negotiations by suggesting that Medi-Cal payments be conditioned on hospital occupancy, with low-occupancy facilities receiving reduced Medi-Cal payments.

industry--as leverage to excise key industry-sponsored amendments. However, this strategy failed when the hospital industry secured "weakening" amendments in SB 1378 in the Assembly Ways and Means Committee. This substantially weakened Keene's negotiating position as well.

After industry-sponsored amendments were made to Keene's bill, the administration opposed it. The Governor's office developed a list of suggested amendments that would have (1) eliminated the "replacement" provision; (2) included power to decertify existing facilities; (3) established a less cumbersome appeals process, and (4) removed the Kaiser exemption. Keene got the appeals process changed in the Senate but could not get support for other proposed amendments.

At the eleventh hour, when the Keene bill was on the Senate floor, the Governor offered to work the floor to get the bill amended to remove the replacement clauses. Keene's reaction was negative. He believed hospitals would kill the bill in the Assembly if amendments were put in on the Senate floor. Also, he had negotiated a compromise with the hospitals in good faith and he resented the Governor's intervening at this crucial moment.

Keene had a difficult time getting enough votes for the bill on the Assembly floor because some members wanted a stronger bill and others were basically against it. Final passage did not occur until 11:58 p.m. on the last day of the session. Meanwhile SB 1378 had also passed the Senate. The Governor then had to decide whether to sign one, or both, or neither of the bills. After two weeks of agonizing comparison, the Governor decided to support a review and control system (AB 4001) and veto the moratorium (SB 1378).

Several observers of the legislative history of AB 4001 were severely critical of the DOH's "abysmal job before legislative committees" and "incompetence and inability to negotiate in the legislative arena." They also observed that the Governor failed to appoint a spokesman for himself while he devoted his attention to

the presidential primaries, and criticized the administration for not effectively negotiating or lobbying to achieve realistic objectives.[89]

The Governor intervened at the last minute and wanted to start all over with a "perfect bill." By this time, the hospital industry had effectively lobbied the Senate and won support for the industry position. There was a late meeting with the Governor when the bill was in Senate Finance in an effort to negotiate amendments to AB 4001. The industry argued that failure to allow replacement of existing facilities would amount to confiscation of property without compensation. The industry "had the votes," and nothing further could be done to strengthen the bill. The industry accepted a few suggestions of the Governor, and the bill was reported out in a form acceptable to them.

LEGISLATIVE ACTION, 1977: A POSTSCRIPT

During 1977 major legislation was considered in the field of health facility regulation, and several important events occurred: Assemblyman Keene introduced AB 1156 to reorganize and expand the duties of the Commission; President Carter announced the introduction of the Hospital Cost Containment Act of 1977 (HR 6575, S 1391); state cost-containment legislation, backed jointly by Governor Brown and Assemblyman Keene, was defeated after opposition from health providers;[90] legislation was enacted (AB 245, Berman) over the opposition of health providers, substantially narrowing the AB 4001 provisions that had exempted replacement facilities from the state's Certificate of Need law for 10 years. Legislative action on these measures is discussed below.

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[89] Legislative, hospital industry, and DOH interviews.

[90] After its failure to pass the Assembly Ways and Means Committee as a rate regulation bill, AB 1156 was amended to remove all of its previous rate regulatory provisions. As enacted, it applied only to the Medi-Cal program.

Rate Regulation

Assemblyman Keene, disturbed by the Governor's criticism of his Certificate of Need bill as weak and by the lack of leadership in the DOH, pointed out apparent conflict between the Governor's public statements and the DOH position on the issue of hospital costs. In an open letter to the Governor dated January 6, 1977, Keene noted that the Governor referred to hospitals as unregulated public utilities. Keene said:

> On the one hand, I have understood your position to be that the functions of the Department of Health should not be increased because it is already overloaded with legislatively imposed responsibilities. On the other hand, top staff of the Department, without contradiction, have consistently taken the position that no other agency but the Department of Health should regulate rates charged by hospitals. A definitive statement from you would be most helpful.

Keene also publicly said that Brown's Health Director "should be removed."[91] He hoped to stimulate the development of administration policy by introducing his own legislation.

As first introduced on March 28, 1977, Keene's AB 1156 was modeled after SB 1107, the Commission-developed budget and rate review legislation, with several important exceptions: The Commission's size was reduced from 15 to 9, including 5 public members and 4 ex officio directors of state departments; rate-setting authority was conferred on the Commission, subject, however, to approval of the Commission's proposed rate-setting method by the legislature in the form of a validating statute. The bill in this form was opposed by CHA, UHA, and the Association of Catholic Hospitals.

The amendments to Keene's AB 1156, sponsored by Governor Brown and introduced on May 10, provided for a five-member full-time Commission in the Health and Welfare Agency, with the Commission Chairman and Commission Executive Director appointed by the Governor. The

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[91] *San Francisco Chronicle*, March 2, 1977, p. 11.

Commission would set maximum rates for billing items (lab, blood, X-ray, etc.) in catagories of facilities (acute hospitals, psychiatric hospitals, clinics, etc.) based on the cost of producing services according to a Commission-established classification scheme. Maximum rates would be phased in for categories of hospitals beginning July 1, 1979. Government purchasers would pay the same rates as other providers by July 1, 1985, but only if the Director of Health certified that approved rates reflected optimum utilization levels.

The administration amendments placing rate regulation in the hands of a Commission rather than the DOH originated early in the Brown administration when the Governor began to explore the establishment of a public-utility-like body to regulate all health care costs.[92] When proposals to expand DOH authority to regulate rates were opposed by the legislature (see Chaps. 8 and 9), the administration began more serious exploration of regulation by the Commission by setting up a task force to explore rate regulatory alternatives.

The task force was composed of DOH, Health and Welfare Agency, Department of Finance and Governor's Office representatives. It concluded that (1) rates should not be regulated by the DOH because it is a purchaser of care; (2) health facility rates should not be regulated by the Public Utilities Commission because of its size and because its activities are unrelated to health; and (3) an independent commission controlled by public members should be established.[93]

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[92]The Governor had been considering rate regulatory alternatives for several years. Upon announcing his program, Governor Brown said, "One of the first things I did as Governor was to try to find a way to control hospital costs and we considered the very thing we're talking about today back in December 1974 . . . we concluded at that time that it just wasn't possible to go as far as we are proposing to do today." A DOH official interviewed also indicated that during 1975 the Governor began discussing the advisability of developing a public-utility-like body for the hospital industry that would be controlled by consumers.

[93]Confidential interview.

At the press conference, Governor Brown supported the need for a government mechanism to control "runaway hospital costs" although he anticipated a "tough fight" to do it.[94] The bill passed the Assembly Health Committee by a 6-2 vote over the opposition of the CMA, CHA, UHA, Kaiser, and Association of Catholic Hospitals. Even though it finally passed the policy commitee by a comfortable margin, it ran into rough sledding at the Health Committee's first hearing because of what several members referred to as "technical problems."[95] Anticipating the difficulty of obtaining Assembly Ways and Means Committee approval, Keene issued a public appeal for support. In a news release he said, "Our only hope of getting this hospital cost containment bill through the Committee and the Legislature is a massive show of public support."[96]

The legislation stalled in the Ways and Means Committee and was amended in several important ways during August before the committee decided to postpone action on it until January 1978. The amendments established the initial rate-setting method as budget and rate review, added review and approval of total facility revenues, and deferred the application of a classification system (1981 for acute facilities and 1984 for other facilities). Although Keene indicated a willingness to accept further significant amendments, these were not acted on once the committee chose not to act on the bill.

In a letter to the Ways and Means Committee Chairman Daniel Boatwright (D-Concord), dated August 25, 1977, Keene announced he was dropping AB 1156 and deplored Boatwright's characterization of it as a "schlock" effort, saying, "Your comments help support those

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[94] Joint Press Conference, May 6, 1977.

[95] *Sacramento Bee*, August 17, 1977.

[96] Ibid., June 5, 1977. All appropriations bills must be approved by the fiscal committees.

who simply don't give a damn about the cost of hospital care to the consumer and the taxpayer."[97] Keene also complained that AB 4001 went into the Ways and Means Committee as a "strong measure" and came out full of "blatant loopholes."

A major point raised by most groups opposed to various versions of AB 1156 was that state action on rate regulation would be premature since Congress was currently deliberating President Carter's program and it was not clear what type of federal legislation might emerge.

Major hospital groups (e.g., CHA, UHA, Catholic hospitals) questioned the Governor's control of appointees saying that the Commission would be an appendage of the executive branch and not independent of the major purchaser of care. They opposed the rate-setting method as being unfair and unworkable. They favored equal payment by all purchasers of care. They also objected to onerous reporting requirements. Kaiser was opposed to the bill's rate-setting methodology, its failure to provide equal payment by all purchasers, and its reporting requirements. Kaiser argued for exemption from the bill but their opposition softened after amendments were made excluding prepayment plans from having to bill their patients. The CMA opposed the legislation because of its preoccupation with cost control at the expense of quality, and objected to the Governor's control of appointees.[98]

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[97]Under amendments proposed by Assemblyman Gordon Duffy (R-Hanford) the Commission would (1) appoint its own Executive Director immediately; (2) take into account specified community needs in analyzing individual hospital budgets; and (3) require the state to appropriate funds to pay for Commission-imposed rate increases affecting Medi-Cal.

[98]See letters of opposition to AB 1156 in the files of the Assembly Health Committee from CHA dated May 3 and August 15, 1977; UHA, June 28, 1977; Catholic Hospitals, July 7, 1977; CSAC, June 8, 1977; CMA, June 6, 1977. Also see *Response to Comments in Opposition to AB 1156*, May 25, 1977, and *AB 1156 Ways and Means Issues with Responses*, August 12, 1977, prepared by Assembly Health Committee.

The bill was also opposed by the County Supervisors Association of California (CSAC) because it might increase costs to counties if tight constraints forced patients from private to county facilities.

There were a number of business, labor and other supporters of AB 1156. Most prominent among business supporters was the Health Insurance Association of America, representing about half the commercial insurance companies doing business in California. Support also came from Ford Motor Company, International Harvester, San Diego Gas and Electric, Rohr Industries, and General Dynamics. Labor supporters included the 160,000-member Service Employees International (AFL-CIO), the United Steel Workers, United Auto Workers, and International Association of Machinists. Other supporters included the Consumer Health Coalition, California Citizens Action Group, and a number of senior citizens organizations. The Governor's office, the Department on Aging, and the Department of Consumer Affairs helped mobilize support for AB 1156.[99]

The defeat of rate regulation legislation in 1977 prompted Assemblyman Keene to support a hospital cost containment initiative measure for qualification during the 1978 general election. As of this writing, a number of AB 1156 supporters are examining the measure. After the defeat of his proposal, Governor Brown said he would continue to work "to bring the hospital-industrial complex into line in a reasonable way." However, he stopped short of endorsing an initiative measure.[100]

Certificate of Need Amendment

Legislation enacted in 1977 removed AB 4001's 10-year exemption from Certificate of Need review for projects entailing replacement or modernization of existing facilities and services.

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[99] See list entitled "Supporters of AB 1156, August 15, 1977," prepared by Assembly Health Committee and letters of support from various organizations contained in files of the Assembly Health Committee.

[100] *Sacramento Bee*, August 27, 1977.

The bill was prompted by initial experience indicating that by June 1977 over $500 million worth of replacement projects had been approved without Certificate of Need review, and hospitals indicated intentions to undertake additional projects costing $700 million. The cost of these remodeling projects was twice that for projects required to be reviewed.

Legislation to totally remove the exemption provision was requested by Governor Brown and introduced by Assembly Majority Floor Leader Howard Berman (D-Los Angeles) as an amendment to a noncontroversial bill that had already passed the Assembly and was to be heard in the Senate Health and Welfare Committee. As enacted, the bill brought bed area remodeling projects costing over $250,000 and other remodeling or replacement costing over $1.5 million under Certificate of Need review. Some projects over these limits may be exempt if need for them can be shown or if the facility agrees not to replace unused beds.

The legislation was opposed by provider groups, including CHA, UHA, the Catholic Hospital Association, Kaiser, CMA. It passed out of the Senate Health and Welfare Committee without the provision affecting remodeling of non-bed areas. This was inserted on the Senate floor and the bill passed the Senate by a vote of 22-14 (21 votes constitute a majority). The bill was not heard in the Senate Finance Committee because the Chairman determined it had no significant state cost implications. It passed the Assembly when the Assembly, by a bare majority of 41 votes, concurred in Senate amendmends on September 14, on the day before the 1977 legislative session ended.[101]

Negotiations held with industry groups failed to produce a compromise, and the bill was enacted despite strong opposition from

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[101]The legislative history of AB 245 is described in a "Dear Colleague" letter dated September 12, 1977, written to members of the Assembly urging their floor support for AB 245. Other information was obtained in discussion with Assembly staff who worked on the bill.

CHA, UHA, and Catholic hospitals. Apparently, key points of industry influence were bypassed when the bill was not heard by legislative fiscal committees. The Governor's office lobbied in favor of it, it was supported strongly by the Chairmen of both the Senate and Assembly Health Policy committees, and it was carried by the powerful majority floor leader, who worked hard to secure its passage. These efforts were strong enough to override industry opposition.

SUMMARY AND CONCLUSIONS

Several themes emerge from the attempts to expand the Commission's role and to contain hospital costs through CES controls and rate regulation. The pressures for government regulation have stemmed primarily from state and federal government purchasers, who have faced dramatically increased costs and sought to contain them by controlling facility expansion and rates. These themes are discussed below.

The response of health providers to cost containment pressure reflects the diversity of California's health care industry. It also reflects the internal struggle between those favoring industry leadership to design effective but acceptable regulatory programs that, in their view, would ensure the industry's financial vitality in return for industry submission to reasonable controls, and those opposing them. For example, CHA early in 1973 initially favored combined rate regulatory and Certificate of Need controls (SB 413), but this was strongly opposed by CMA and UHA. Opponents refused to believe that expanded regulation could be benevolent; they feared it would be controlled by purchasers of care and that it would negatively affect their interests. The 1974 CHA Task Force report recommended a combined regulatory agency, but modified its stance following negotiations with CMA and other hospital groups to produce a compromise. CMA and UHA agreed to support a regulatory program with separate rate regulatory and Certificate of Need bodies. To the extent these groups would accept regulation, they preferred that it be fragmented and also that it contain procedural due process safeguards (i.e., de novo judicial review).

CHA and UHA were at odds when, early in 1975, CHA supported inclusion of replacement and remodeling of facilities as part of Certificate of Need regulation. UHA opposed this just after having successfully sponsored 1974 legislation to gain this exemption.

More recently, CHA, CMA, UHA, and Kaiser policies have generally coincided in opposing rate regulation and supporting exemptions for replacement and remodeling. It appears that CHA has backed away from previous support of comprehensive government regulation to a more antiregulation posture similar to that of CMA, UHA, and Kaiser.

Kaiser's legislative activities primarily reflect the desire of a prepaid group practice system to gain legislative recognition of the difference between its program and those of other providers. Kaiser has sought exemption from regulations that would restrict its ability to expand. Initial efforts by Kaiser to gain complete exemption were resisted by other providers. It appears that Kaiser opposes regulation partly because the regulatory process might be geared to the needs of other hospital and physician providers and Kaiser's interest might get short shrift. Kaiser has not always won exemption from proposed regulation, but has been able to negotiate compromise provisions that recognize the special nature of prepaid group service plans.

The legislature's general unwillingness to enact health facility programs that would be unacceptable to providers reflects the political influence of provider groups, the lack of an effective constituency supporting government regulatory efforts, and the uncertainty of some legislators about the value and effectiveness of such efforts.

Legislative efforts supported by both Governors Reagan (SB 413) and Brown (AB 1156) to expand the Commission's role were unsuccessful largely because of industry opposition, which was most effectively exercised in the legislature's fiscal committees. Although major administration-backed legislation failed, more modest efforts to expand the Commission's role, supported by the industry, were enacted (AB 2123), reinforcing the view that legislative outcomes on proposals

affecting the Commission reflected provider objectives. The defeat of these bills also illustrates the lack of substantial support for regulatory controls by groups with enough political influence to counterbalance providers. There was also no effective constituency supporting 1975 Commission-sponsored legislation (SB 1107). This was not supported by providers and was opposed by the Brown administration. The administration's failure to gain sufficient support for AB 1156 was also based partly on uncertainty about the effectiveness of government regulatory programs. Given this uncertainty, some legislators were unwilling to risk "taking on" providers when they were unsure about the fruits of their victory.

State Certificate of Need implementing legislation enacted in 1976 (AB 4001) was satisfactory to the industry, and unsatisfactory to the Governor and the bill's author, primarily because of effective industry lobbying and lack of effective countervailing pressure by the administration. Failure to enact stronger legislation was also attributable to what some legislators viewed as the DOH's inability to make a good cause for it and their overall lack of confidence in the DOH's administrative performance. Moreover, Assemblyman Keene's unsatisfactory experience with the DOH and the Brown administration during negotiations on this bill helped lead him toward the Commission as a potential rate regulator. *Legislative success in narrowing facility exemptions from Certificate of Need review despite industry opposition (AB 245) resulted when the fiscal committees in both houses were bypassed. Lobbying by the Administration and the bill's author apparently was more effective than it had been on AB 4001.*

The response of California State government and affected providers to cost containment pressures was influenced by federal actions. First, the imposition of price controls stimulated the desire of provider groups for delegation of authority to an independent state commission. Second, the experience of California hospitals under controls helped dissuade many from support for any program of rate regulation. Third, following the complete removal of price controls, hospital support for state controls gradually evaporated. Fourth, state action to institute Certificate of Need controls was stimulated

by the requirement of PL 93-641 that state implementing legislation be enacted. The state legislative struggle was over the timing and specific content of state implementation. Fifth, cost-containment legislation proposed by the Carter administration has been a major factor in the cost-containment debate in the California legislature. The threat of federal preemption, and the lack of knowledge about the specific nature of a state option in the Carter-sponsored legislation, introduced still greater uncertainty into legislative decisionmaking on an already complex issue and helped lead to the defeat of Governor Brown's program.

Chapter 8
COMPETITION BETWEEN THE DEPARTMENT OF HEALTH AND THE COMMISSION FOR CONTROL OF HEALTH FACILITY NONFINANCIAL DATA

INTRODUCTION

The Department of Health (DOH) and the Commission have been competitive bureaucracies. When the Commission was first established, conflict was minimal, but it intensified as the Commission's responsibilities grew and attempts to expand its powers and duties continued. This chapter reviews the history of the conflict and explores one aspect of it: the struggle for control of health facility nonfinancial data.

HISTORY OF THE CONFLICT

All Commission members and staff and DOH personnel interviewed in 1976 and 1977 knew of the competition between the Commission and the DOH over who should set rates (and by what method), who should administer the state Certificate of Need program, and who should control health facility data.

When the Commission was created it was not viewed as a threat to the major departments then administering health programs (1972). The Department of Health Care Services, which administered the state Medi-Cal program, was interested in getting better data on Medi-Cal costs and favored the establishment of uniform accounting and reporting systems, and there was no opposition from the Department of Public Health. Some Department of Health Care Services personnel were recruited to help staff the Commission.

The creation of a single Health Department out of previously separate health agencies in 1973 had important implications for the Commission. The purpose of the Reorganization Plan, which consolidated the functions of the heretofore separate Departments of Health Care Services, Public Health, and Mental Hygiene into a unified Department of Health, was to bring as many health-related activities

as possible under one roof. The existence and expansion of an independent health regulatory Commission, with a legal mandate to develop a hospital economic stabilization program and serve as a central repository for collection of health facility data, ran counter to the principle of unified DOH management of all health-related functions. The leadership of the new DOH, appointed by Governor Reagan, began to see the Commission as competitive and to adopt a posture of "wary coexistence" with it, but had no desire to "do battle." Instead, efforts were made to compromise differences and not to air disputes in public.

In 1974 the DOH leadership was cool toward the CHA Task Force Report recommending major expansion of the Commission's powers. DOH officials now saw the Commission as an "industry dominated" competitor. When Health and Welfare Secretary Brian resigned to campaign for the U.S. Senate early in 1974, both the Commission and the DOH were less constrained by administration policy to pursue their own objectives and conflict began to escalate. According to some Department staff, the Commission refused to compromise with the DOH on major issues of rate regulation and Certificate of Need. DOH representatives from the Medi-Cal Division, some of whom participated in the deliberations of the Commission's Rate Review Subcommittee, opposed the requirement that the state pay Commission-established rates, because they would substantially increase state Medi-Cal costs. In their view the Commission was marching in step with the industry without sufficiently emphasizing cost containment or considering how its proposals would affect the State budget. The Commission's development of its economic stabilization program ignited further conflict over the two agencies' future rate-regulatory powers. The DOH also felt it should administer CES controls.

During the Brown administration the DOH attitude shifted from wary coexistence to open confrontation. Health Director Dr. Lackner and Health and Welfare Secretary Mario Obledo were not unfriendly toward the Commission when they first came to office in 1975. Commission affairs received "low priority" despite repeated efforts by

the Commission Chairperson to participate actively in the new administration.[1]

Key Brown administration officials viewed the Commission as unduly influenced by health providers--a tool of the Reagan administration whose appointees could not become trusted members of the new administration's "team."

In the fall of 1975, after an ad hoc DOH policy group set up to advise the Director recommended that the Commission be phased out, the Director of Health opined that both rate regulation and Certificate of Need functions should be housed in the DOH.[2]

Soon after, the Health and Welfare Secretary told the Commission Chairperson, at a December 1975 meeting, that the administration had decided to phase out the Commission. In June 1976, at Obledo's request, the DOH prepared a "position paper" calling for the abolition of the Commission. It pointed out that the Commission's efforts to expand its authority were in "direct conflict" with DOH programs and policies in three major areas: (1) control of data and information resources for health planning, services development, and evaluation; (2) rate-setting authority; and (3) Certificate of Need authority. The conflict escalated when both agencies submitted competitive projects to the Social Security Administration (SSA) for federal studies aimed at developing rate-setting methods. Legislative hearings on these two proposals pitted the agencies against one another in an adversary proceeding. (Chapter 9 discusses the fate of the competitive study projects and the administration's effort to phase out the Commission.)

Proposals to phase out the Commission and expand the duties of the DOH were considered during a period when the DOH was receiving strong criticism from the state's "Little Hoover Commission" and the legislature. Instead of reducing or eliminating the Commission, the legislature chose to break up the DOH.

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[1]Interview with Phyllis Smith.

[2]Interview with Bamford Franklund, April 27, 1977. This position was publicly stated before the Assembly Health Committee on October 16, 1975.

THE "EMBATTLED" DEPARTMENT OF HEALTH

The implementation of the Reoganization Plan creating the DOH has had a stormy history, culminating in the passage of 1977 legislation to dismember it (SB 363, Gregorio). The plan was first enacted in 1971 on recommendation of the Reagan administration, but there was little enthusiasm for its implementation once its original proponents left the administration.[3]

The 1976 report of the Little Hoover Commission concluded that the DOH was "concocted" with lack of both caution and planning, and "produced resentment and rivalry" instead of greater cohesion and functional integration. They found that a loose federation of autonomous programs "continued to operate independently with little evidence of increased cooperation." They did not recommend breaking up the DOH, however; instead they proposed that the Governor "enunciate clear health goals" and that a State Board of Health be established "as a publicly accountable body to review major health policies." They also proposed other changes designed to improve planning and evaluation, bring more qualified professionals into positions of responsibility, and promote better relationships with providers and other levels of government.[4]

Although some administrative changes suggested by the Commission were adopted, the Governor vetoed a major bill that would have established a State Board of Health (SB 1779, Beilenson).

The DOH came under attack in the legislature for poor management of prepaid health plans, deaths in state mental health facilities, and bad handling of legislation. Legislative dissatisfaction culminated in the Assembly Health Committee Chairman's calling on

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[3]The author was a consultant to the Health and Welfare Secretary assigned to monitor planning for reorganization during its early phases in 1971 and 1972.

[4]*A Study of the Administration of State Health Programs*, Commission on California State Government Organization and Economy, 1976, pp. 5, 6, 29, 30.

Governor Brown to remove Dr. Jerome Lackner, the Director of Health and a self-styled "lousy administrator."[5]

Senate Health and Welfare Committee Chairman Arlen Gregorio announced introduction of legislation breaking up the DOH into smaller departments. His aide called the "experiment of a single department . . . a failure." Another legislative aide called Governor Brown's support for the proposal a political response reflecting the Governor's "inability to handle the political liabilities that go with the department." Another criticized it as leading to "destructive competition" among the new departments likely to impede the State's ability to cope with major health policy issues.[6] Despite some opposition, the legislation was supported by most health-provider groups and was enacted.[7]

THE ISSUES WITH HEALTH FACILITY NONFINANCIAL DATA

The DOH maintained that it should manage health facility data to ensure responsiveness to the needs of users and of program managers who are located in the DOH. The Commission claimed the same responsibility because (1) the Disclosure Act mandated it to collect financial data, and (2) its authority was subsequently expanded by 1973 legislation to establish a comprehensive data system for all facilities including facility nonfinancial data. Commission efforts to control health facility data were supported both substantively and politically by the CHA.

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[5]Dr. Lackner, an internist, is personal physician to United Farm Workers President Cesar Chavez, and has marched in UFW picket lines. *Sacramento Bee*, October 21, 1977, and *San Francisco Chronicle*, March 2, 1977.

[6]*San Francisco Chronicle*, loc. cit.

[7]SB 363 dismantled the DOH and established Department of Health Services (including public health and Medi-Cal programs), Mental Health, Developmental Services, Social Services, and Alcohol and Drug Abuse. Health planning activities were to be transferred to the Health and Welfare Agency.

The Commission's Legal Authority

CHA-sponsored legislation enacted in 1973 (AB 2123, Hayden) mandated the Commission to:

> establish approved systems of health facility accounting, uniform reporting and auditing to create, to the extent feasible, *one uniform, comprehensive state system which takes into account the data requirements of all state programs*. The Commission shall make available information required by other state agencies for programs they administer or in which they have an interest. (Section 441.16(c).)

The bill did not preclude other state agencies from collecting data they needed for their programs; it said they should use the Commission system "to the maximum extent feasible."

AB 2123 was aimed at implementing CHA policy that the Commission should be "the sole state agency" authorized to require hospital financial reports and audits for use in all state programs.[8]

CHA's purpose was to free hospitals from the duplicate reporting requirements imposed by numerous state programs involved with Medi-Cal, comprehensive planning, licensing, mental health, and crippled children. The proposal was a by-product of CHA's federally funded Hospital Effectiveness Demonstration Project.[9] An implicit objective of CHA was to ensure that control over health facility data would be exercised by a "friendly" agency outside the DOH.

The CHA approach was supported by an independent consultant who recommended to the Commission that:

1. The commission serve as the central repository for all existing reports presently prepared by hospitals.

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[8] *California Hospital Association Policy on State Reporting and Auditing Requirements*, adopted January 11, 1973.

[9] Gordon Cumming and Henry Zaretsky, *Hospital Effectiveness Demonstration Project*, Final Report, November 30, 1974, p. 6.

2. Hospital financial reporting requirements be simplified, reduced, and made more useful.

3. A single audit be developed to serve the needs of several governmental units conducting separate audits.[10]

A problem the Commission faced in seeking to implement this language was that it did not place sanctions on other agencies requiring them either to use the Commission-developed system or receive Commission approval before they could collect their own data. This charge would have been difficult enough to administer with agencies working cooperatively through a central system, but was impossible with agencies in conflict. The Commission was given a charge without sufficient muscle to implement it.

Early Competition

Early conflict between the Commission and the DOH over the implementation of the new statute broke out in the spring of 1974 when the DOH's Comprehensive Health Planning Unit attempted to get Commission endorsement for its proposal to the National Center for Health Statistics to develop health facility and patient care statistics. This was in response to a Request for Proposal from HEW for development and implementation of the Cooperative Health Statistics System. CHA and UHA representatives argued that under AB 2123 the Commission, not the DOH, should collect these data and opposed endorsement of the DOH proposal.[11] The competitors compromised by agreeing that both of them would submit proposals and set up a Joint Policy Committee to coordinate their activities. The DOH submitted proposals to accomplish planning and development

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[10]Mary Lee Ingbar, *Hospital Costs and Efficiency, A Report to the California Hospital Commission on Its Prospects and Problems*, June 20, 1973, pp. 10-24.

[11]Minutes of Meeting, April 3, 1974.

activities in health manpower statistics and health facility statistics, and the Commission in hospital care statistics. Each agency endorsed the other's proposal.[12]

CHA and UHA representatives agreed to support the compromise provided it was clear that the Commission would be the manager of the coordinated data system and collect the required data as provided by AB 2123.[13] In a letter summarizing the results of discussions between the Commission and the DOH, the Commission Chairperson said that the DOH recognized the Commission's responsibility "to create and administer a data collection, storage, and reporting system which would replace, to the extent possible, all other such activities carried out by the Department of Health with respect to health care institutions.[14]

The Commission's efforts were to be devoted to planning for its Part II and Part III data systems. The Part II system was to consist of a comprehensive questionnaire and system to collect mostly non-financial hospital care data to meet the needs of users and to reduce the burden on hospitals resulting from many "unique and fragmented requests for data." One of its major objectives was to simplify and centralize health facility data dissemination to state agencies.[15]

The Part III system was to consist of inpatient discharge information. The project was intended to test whether a single private medical abstracting agency could function as a "data intermediary" for state government, producing valid hospital care statistics while preserving the anonymity of hospitals, patients and physicians. Commission staff members who were interviewed called Part III a success.

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[12]Commission Minutes, April 17, 1974.

[13]Ibid.

[14]Letter from Commission Chairperson Phyllis Smith to William E. Mayer, Director, Department of Health, May 9, 1974.

[15]*Commission Quarterly Progress Report* for the period July 1-September 30, 1974, under Contract HRA-106-74-131, and interview with Commission's staff.

The DOH project was to develop a health facility data base, supply HEW with a basic data set on these facilities, and reduce the data demands on them.[16]

Besides these two projects, the CHA also sponsored a similar one funded by a different HEW agency. Soon after the Hayden bill passed, the CHA received Commission endorsement for a proposal to the National Center for Health Services Research designed to reduce data demands on hospitals.[17] CHA was awarded its grant, and work on all three projects began about the same time.

THE THREE FACILITY DATA PROJECTS

Because they were similar in scope, efforts were made to coordinate the three projects. It was decided that the DOH would emphasize "tracing data uses within the department," the Commission "necessary liaison with other state agencies," and the CHA "the hospital industry's role in the data gathering process."[18]

Department of Health Project

The DOH was to examine the devices used to collect data and describe the process by which information was made available to decisionmakers. The DOH produced an interim report subtitled *Questionnaires Don't Work*, which found

> that questionnaires do not produce very much information; that they rarely serve the Department's decisionmaking process, but rather exercise a hidden and largely destructive policy formulation impact on the industry. Simultaneously, they create the need for many thousands of hours of manpower processing time within the Department.[19]

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[16] *Department of Health Comprehensive Health Planning Unit Quarterly Progress Report*, under Contract HRA-106-74-162, September 4, 1974.

[17] Commission Minutes, February 19-20, 1974.

[18] Gordon Cumming and Henry Zaretski, *Hospital Regulatory Reporting System (HRRS): A Demonstration, Final Report*, September 30, 1975, p. 7.

[19] *Interim Report, An Action Plan for Questionnaire Reduction and Control in the California Department of Health*, prepared by W. R. Bell et al., October 1975, p. 1.

It is recommended that the use of questionnaires be discouraged; instead, facility data should be "collected by on-site interviews and observations conducted as an integral part of the licensing process."[20] The CHA called the report impractical and inappropriate because (1) licensing staff would not be able to collect accurate data, and (2) general reduction in use of questionnaires for certain programs was not justified without "firm evidence about ineffective use of data." The DOH later abandoned this approach.

The CHA and Commission Projects

The Commission concentrated on analyzing the data systems of other state agencies and identifying similarities in data objectives and in the questionnaire information they requested.[21]

The Commission invited the CHA to work with it in developing the Commission's Part II data system because the CHA's project held such great potential value for both their systems.[22]

Hospitals returned 385 questionnaires to the CHA, which shared them with the Commission (and with DOH). The system to analyze and classify questionnaires was developed jointly by both agencies. CHA thereupon recommended strengthening of the Commission's responsibility for data collection, because "presently, California law requires State agencies to use the Commission's data resources only as feasible; and this 'loophole' has led to rivalries among the agencies as to who should be the primary data collector."[23]

The primary result of the CHA project was the design of a comprehensive questionnaire consolidating the needs of eight state

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[20] Ibid., p. 39.

[21] Commission Third Annual Report, November 1, 1974, p. 9.

[22] Second Quarterly Progress Report, January 13, 1975.

[23] CHA Final Report, p. 55. One difference between the two projects was the Commission's emphasis on incorporating the National Center for Health Statistics Minimum Data Set.

agencies. A major finding of the study was that private organizations rather than the government generated the most demand for hospital data. Almost 70 percent of the questionnaires CHA collected came from private organizations.[24]

Although the Commission worked cooperatively with the CHA, there were points of disagreement. In a January 31, 1975 memo to the Advisory Council, staff proposed that the Commission develop regulations to implement the Part II data system once there was agreement on a final data set. This would put hospitals and state agencies "on notice" regarding their roles and responsibilities under the uniform reporting system. The suggested regulations would have provided for semiannual reporting and required the Commission's prior approval of other agencies' data collection efforts.

CHA opposed these suggestions as premature until they had completed their own project and the final questionnaire was tested. CHA also opposed semiannual reporting. The Commission Advisory Council decided that more work was needed before implementation and instructed the staff to work with CHA to resolve their differences.

At the end of August 1975 the Commission's Draft Questionnaire was completed. It was then reviewed by other state agencies and by NCHS and tested on a sample of 9 hospitals. The field test suggested that the Commission's proposed questionnaire could replace from 8 to 29 other questionnaires.[25]

OPEN CONFLICT

After the change in gubernatorial administrations, the conflict between the DOH and the Commission escalated, culminating in the DOH's refusal to cooperate with the Commission.

At the first meeting of the Joint Policy Committee after a new Health Director was appointed, conflict between Commission-sponsored

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[24] Ibid., p. 3.

[25] The Commission staff took 373 questionnaires assembled by CHA and eliminated those that could not be replaced by future implementing Commission regulations. There were 189 questionnaires remaining.

rate-regulation legislation and DOH-backed Certificate of Need bills was discussed.[26]

At the second meeting the major issue was whether the DOH would support the Commission's legal mandate to develop a comprehensive uniform health facility data reporting system. The DOH agreed to evaluate the feasibility of using a central reporting agency to meet its needs, noting that the DOH could contract with the Commission to collect its data.

During the next several months, key decisions were made that placed the Commission and the DOH at loggerheads. In a letter responding to the Commission's request that the DOH appoint a representative to a newly created Data System Advisory Panel, the Director of Health concluded that:

> We find there is no feasible way for the Department to relinquish its data gathering responsibilities which are well founded in law and accepted practice . . . We find no justification in law for the Commission to go beyond the collection of financial information . . . We have elected not to provide a representative to your Data System Advisory Panel.[27]

DOH officials believed that the primary users and program managers should define the data base to meet their needs. They objected to going "hat in hand" to the Commission to satisfy their own requirements.[28]

Because of conflict and duplication of activities between the Commission and the DOH, the National Center for Health Statistics was dubious about continuing the two contracts, and sent letters to the two agencies urging them to reach agreement.[29]

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[26]Minutes, Joint Policy Committee Meeting, May 20, 1975.

[27]Letter from Dr. Jerome Lackner to Robert Murch, February 22, 1976.

[28]Interviews with DOH staff.

[29]Letters to Dr. Lackner and Robert Murch from Gail F. Fisher, March 23, 1976.

To document its legal authority, the Commission obtained an opinion from the State Attorney General that confirmed the Commission's responsibility to collect nonfinancial data as part of its comprehensive health facility data system. It concluded, however, that the Commission could not issue regulations precluding other state agencies from requesting data from facilities without Commission approval.[30]

Federal officials were invited to the next Joint Policy Committee meeting, which was held to reconcile differences between the two state agencies. The federal officials emphasized that NCHS wanted only one health facility data contract in California and that the State itself should make the choice. The DOH argued that it was the largest data user and had established a Center for Health Statistics, which would be the appropriate place to manage the state's input to the NCHS program. The Commission cited its legal authority, validated by the Attorney General, to collect nonfinancial data, and pointed out that the hospital industry was opposed to locating the health facility data component in the DOH.[31]

After the meeting the NCHS extended both contracts until June 30, 1977, pending the state's choice between the two agencies.

During May the major policy questions concerning transfer of the Commission's responsibility and the fate of the DOH's SSA project were subjects of Commission and DOH conflict before the legislature. To support transfer of the Commission's functions to itself, the DOH argued that this would resolve conflicts over the NCHS project and allow the DOH to get the NCHS operational contract. Despite policy differences, the Commission and the DOH agreed to cooperate on a technical basis on their respective projects.[32]

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[30] *Attorney General's Opinion CV 76/59, June 3, 1976.*

[31] The Commission's 1976 Annual Report, and Minutes of Joint Policy Committee Meeting, June 21, 1976.

[32] The DOH contracted with the Commission to process data from its annual questionnaire to health facilities because the Commission's cost was considerably less than that of the DOH's own data processing system.

In a May 9, 1977 report to the Commission, its staff asserted that the Commission's tasks under the NCHS contract were completed and the results ready for use "unless prevented because of limitations in our law or because of past administrative disagreement by the Department of Health."[33] The failure of the DOH and other state agencies to participate in the implementation of the system using the Commission-developed questionnaire effectively killed the Commission's Part II data system.

At the request of the NCHS the Commission's contract was extended to September 30, 1977, to permit further exploration of issues involved in California's participation in the nationwide Cooperative Health Statistics System (CHSS).

RECENT EVENTS

The NCHS has backed away from its previous position that only one operational contract should be let in California. At present two contracts are being considered, one proposed by the DOH for collecting health facility statistics that would involve the Commission as a subcontractor, and another suggested by NCHS under which the Commission would manage a "data consortium" to collect patient care statistics.

Under the DOH proposal, data would be generated to serve the DOH's planning and Certificate of Need programs and meet the requirements of the NCHS "minimum data set."

The Commission would process data obtained from the DOH's annual licensure survey, as it is now doing under recent contract. Financial data would also be supplied from the Commission's disclosure reports.

The Commission is exploring a possible contract initiated by NCHS to collect patient discharge information as a follow-on to its Part III system developmental work and as useful information for the Commission should it be given future rate setting responsibilities. The recently created HEW Health Care Financing Administration (HCFA) is also interested in obtaining similar data.

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[33] Memo to the Commission from Executive Director Robert Murch, May 9, 1977.

Thus, with the Commission having survived efforts to kill it, the Commission and the DOH are now cooperating to serve state and federal health facility data needs. It is likely that the DOH will receive an operational contract to collect health facility statistics as part of the Cooperative Health Statistics System with the Commission as subcontractor. Whether the Commission chooses to manage a system to collect patient discharge information depends in part on the willingness of California hospitals to cooperate as members of a "data consortium."

SUMMARY

Control over health facility nonfinancial data illustrates one aspect of conflict between the Commission and the DOH as competitive bureaucracies. When the Commission was first established it was not viewed as a major threat to DOH interests; conflict arose, however, after it was authorized to develop a single uniform health facility data system to serve the needs of all state agencies. Upon taking office, the Brown administration at first ignored the Commission and then tried to phase it out because it was viewed as overly sympathetic to providers, as a holdover agency still controlled by Governor Reagan's appointees, and as competing with the DOH for rate regulatory and CES controls and for control over health facility data. The major casualty of legislative action, however, was not the Commission but the DOH. Growing dissatisfaction with the DOH's performance resulted in the passage of legislation to break it up into smaller health units.

The hospital industry sought to expand the role of the Commission as an instrument to help reduce data demands on hospitals. This was supported by the Commission's own independent consultant, who recommended that it serve as a focal point in state government for facility data. AB 2123, enacted in 1973, empowered the Commission to establish a single uniform comprehensive health facility data system. An underlying objective was to have the Commission, with industry representatives among its members, control the use of health facility data.

Passage of the statute proved easier than its implementation. As the prime state user of facility data, the DOH resisted the Commission's efforts to implement this change. The legislation failed to provide sufficient authority to "muscle" other state agencies into becoming part of the system. When the DOH's Comprehensive Planning Unit requested Commission endorsement for its proposal to collect health facility data as part of the national Cooperative Health Statistics program, the Commission and the industry rebelled. An initial compromise was worked out under which both agencies applied for and received federal planning and development contracts. The efforts of the two agencies were coordinated through a Joint Policy Committee.

Soon after a new Director of Health was appointed by the Brown administration, conflict between the Commission and the DOH broke out into the open. The DOH refused to participate in the Commission's effort to administer a single questionnaire, and questioned the Commission's legal authority to collect nonfinancial data. The CHA received its own grant to work with the Commission on the design of the data system, opposed DOH management of the data system, and criticized the results of the DOH's NCHS project. Conflict about data became part of the overall conflict among the Commission, the DOH, and the Brown administration over Certificate of Need and rate regulation. The DOH's position favoring transfer of the Commission's function rested in part on overlap and duplication of data collection efforts.

Federal actions influenced the way the state proceeded to collect health facility data. Federal funds supported efforts of the Commission, the DOH, and the CHA. The NCHS became concerned about the internecine warfare in California and called upon the state to settle its differences so that one contract could be issued for the operation of the CHS system in California. With the California program in possible jeopardy, the Commission and the DOH agreed to disagree on policy but work together on their projects. With the failure of the DOH to obtain transfer of the Commission's function, the issue of

which agency will manage the CHSS is yet to be resolved. NCHS contracts have been extended while alternative approaches are being explored. This resulted in the DOH's contracting with the Commission to process its data. With the failure of efforts to abolish the Commission and NCHS willingness to consider more than one operational contract in California, the DOH has proposed an operational contract for a health facility data collection system utilizing the Commission as a subcontractor. Also, NCHS and HCFA are interested in contracting with the Commission for hospital discharge data.

Chapter 9
THE COMMISSION'S FIGHT FOR SURVIVAL

This chapter explores in further detail the development and fate of competitive rate study proposals by the Department of Health (DOH) and the Commission, and the course of events following the Brown administration's announcement that it favored abolishing the Commission.

SSA PROJECT DEVELOPMENT

Section 1526 of PL 93-641 authorized funding of demonstration projects in six states that had authority to regulate rates or at least stated their intent to do so. The SSA request for proposal allowed two types of proposals aimed at cost containment. Type I was to test a fully developed rate-setting method to be implemented on an experimental or demonstration basis, and Type II was to develop rate-setting methods.

In California, the Commission, the DOH, and the CHA submitted project proposals to the SSA. The stakes were high, for the winning agency would be the prime candidate later on as the state's rate-regulation authority.

The Commission Project

Conflict arose between the Commission and the DOH during the early days of project development (1975). Soon after federal legislation authorizing rate studies was enacted, the Commission sought state legislative authority to conduct a demonstration project and began project planning. However, Commission-sponsored legislation (SB 1108, Beilenson) was dropped by its author after the DOH opposed it and the Assembly Health Committee questioned the need for it. The bill was supported by CHA. The DOH opposed it because "a potential exists for the Commission to be dominated by the very industry it is ultimately

charged with the regulating . . .," and it would preclude the DOH from receiving federal project funds for rate review.[1]

After defeat of SB 1108 the Commission chose to submit a developmental proposal (Type II). The Commission's Task Force on Short and Long Range Objectives was given the task of designing a project approach that would be consistent with the Commission's economic stabilization report.

The Commission's proposal and its Task Force report were developed in a climate of lively competition with the DOH, and the Commission's developmental work proceeded on a confidential basis. The Commission contracted for the assistance of Dr. William Dowling of the University of Washington. Industry representatives were invited to participate in Task Force deliberations, which began in July 1975. The Task Force Report became the basis for the Commission's SSA proposal, submitted in January 1976, which called for a two-year project and requested $936,165 in federal funds.

The Commission Task Force Report recommended a budget and rate review approach with multiple screens to eliminate the need for detailed review of individual hospital budgets. The report was opposed by CHA and other hospital groups. Most controversial were its recommendations that an Aggregate Cost Increase Target (ACIT) be established and that rate regulation be used to phase out unneeded facilities and services. The ACIT was conceived as an allowable percentage increase for the industry as a whole, to be established each year in the light of testimony by economists, providers, and purchasers. The target would guide Commission budget review and

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[1] Letter to the Assembly Health Committee from DOH Director Dr. Jerome Lackner, August 14, 1975. There were a number of reasons why the legislation was not needed. First, PL 93-641 required that funds for such studies would have to be approved by the State Designated Planning Agency and this was unlikely since this agency would be the DOH. Second, SSA indicated that it would be soliciting proposals under a previously authorized program established under Sec. 222 of the Social Security Act and that the new program would be administered in conjunction with the old one. Third, the six-month federal deadline requiring state action establishing intent to regulate rates had passed without final state legislative action.

would be adjusted year by year as system inefficiencies improved. Individual hospitals would be allowed either more or less than the ACIT. Facilities and services deemed unneeded by planning agencies would be phased out. Financial requirements of needed hospitals would be met, including operating costs, bad debts, education, rate of return for investor-owned facilities, and surplus for nonprofits.[2]

The system goals proposed by the Task Force were to (1) contain costs; (2) meet the financial requirements of "a needed number and distribution of hospitals, beds, and services"; (3) eliminate subsidy of one purchaser by another; and (4) integrate budget and rate review activities with licensing activities of DOH, planning and capital expenditure controls of agencies, and utilization of controls of Physician Standards Review Organizations (PSROs). The Commission Task Force recognized the separation of budget and rate review and Certificate of Need functions in different agencies.

Under the proposed system, to be phased in over three years, hospitals would be grouped according to patient mix, similarity of services, markets, educational programs, and other attributes. Budgets would be screened, and those exceeding cost guidelines set aside for detailed review. Rates would be charged to meet only approved budget requirements. A hospital failing to pass a screen could file a request for exception. Review of prepaid group plan hospitals would be limited to budgeted costs.

The UHA representative withdrew when the group proposed that unneeded hospitals be decertified. Some industry opposition was anticipated and even welcomed as proof that the Commission "was not in bed with the industry," as one interviewee put it. Because CHA participants took the lead in helping develop the proposed cost containment program, Commission staff expected that the report would be accepted by CHA and had a reasonable chance for implementation.

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[2] *A Proposed Budget and Rate Review System for California Hospitals*, prepared by the Task Force on Short and Long-Range Objectives of the California Health Facilities Commission, January 5, 1976.

Industry Positions

Instead, the CHA opposed the report for departing from previous Commission policy; it suggested major study and revision involving health industry groups. CHA particularly objected to the ACIT and to the phasing out of facilities and services. It contended that budget and rate review should not be used to achieve changes in the hospital industry as a whole. It decried prospective rate review, saying it was not an incentive for efficiency but "a club to carry out arbitrary financial controls of the health system."[3] Nonetheless, the CHA embodied the *same principles* in its proposal to SSA, which was developed by the same staff that helped develop the Commission's Task Force report. Apparently, CHA was not ready to accept these principles for statewide application, but it did recommend that the program be given a regional experimental test.[4] Some industry observers called CHA's opposition to the Commission's report "a major policy shift" from its previous support of budget and rate review. It prompted the resignation of CHA's long-time liaison with the Commission, a CHA past president.

Surprisingly, the CMA response was more favorable than that from CHA. The CMA was pleased with the Commission's decision to separate budget and rate review from Certificate of Need decisions and found "no major problems" with its general content. However,

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[3] Letter to Commission Advisory Council from CHA President William Whelan, April 15, 1976. Three CHA committees reviewed the report. The Research and Development Committee endorsed it as generally "consistent with established CHA policy." The Financial Management Committee found it "inconsistent, contradictory, arbitrary and confusing" and opposed the ACIT principle of closing hospitals through rate setting. The Hospital Planning and Licensure Committee questioned the constitutionality of phasing out unneeded hospitals without just compensation. All three committees recommended that the process envisioned by the Task Force be tested on a regional rather than statewide basis.

[4] Ibid.

they did raise questions about the Commission's development of efficiency standards for provision of services and the phasing out of unneeded facilities and services.[5] The California Radiological Society raised concern about the ACIT as a device that "may well stifle needed innovations." It also raised questions about efficiency standards and objected to the inclusion of professional fees as subject to prospective rates and suggested these fees be considered on a "pass-through" basis only.[6]

The President of The California Society of Anesthesiologists viewed the growing powers of the Commission as a frightening rush toward socialism.[7]

After receiving comments from interested organizations, the Commission's Advisory Council recommended "some points of emphasis" to be appended to the report as a basis for further development of the Commission's proposed budget and rate review methodology. The Council averred that decertification should not be part of the budget and rate review and approval process. It recommended that the staff study "alternative ways of coordinating economic sanctions to determine how equity might best be achieved" through the budget and rate review and approval process.

It also recommended that:

1. ACIT be subjected to further study.

2. All parties must agree in advance to provide equal payment.

3. Philanthropy as a means of raising capital be encouraged.

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[5]Letter to Commission Advisory Council from CMA President Dr. Ralph Milliken, April 15, 1976.

[6]Letter to Commission Advisory Council from Robert H. Reid, President of California Radiological Society, March 24, 1976.

[7]Letter to Commission Advisory Council from Dr. Donald B. Dose, President of California Association of Anesthesiologists, April 5, 1976.

4. No differentiation be made between taxpaying and nontaxpaying hospitals concerning retained earnings (surplus).

The Council's recommendations modifying the Task Force report were accepted by the Commission.

The Department of Health Project

The Department chose to develop its own SSA Type II developmental project after deciding that it should regulate hospital rates. It prepared its proposal at the eleventh hour on a crash basis without consulting the industry, which was opposed to the formula type of rate-setting approach the DOH intended to use because in their view this approach was more likely to achieve cost containment objectives.[8] The initiative for the proposal came from the DOH Rates and Fees Section. Under the proposal, hospital budgets would be submitted and formula applied to them using economic indices, forecasts, and standards of performance to produce an allowable expenditure level for the future budget year. The expenditure level would be based on predetermined cost containment and productivity objectives. Aggrieved hospitals could appeal to a Rate Appeals Board.[9]

The CHA Project

The CHA had been negotiating with the SSA for several years to conduct an experimental budget and rate review project in California to design methods implementing the recommendations of CHA's 1974 Task Force on Government Regulation. A Phase I developmental effort called the Prospective Incentive Payment Experiment (PIPE) was funded by SSA,

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[8] Interviews with Department of Health staff.

[9] *Summary of The Department of Health's Rate Setting Project*, undated, prepared for presentation to legislative committees.

resulting in the design of a three-year experimental project. (PIPE was not to be bound by CHA policy, nor was CHA expected to be bound by project results.) The Commission supported PIPE Phase I, whose final report acknowledged that it profited from many of the ideas generated by the Commission's Task Force on Short and Long Range Objectives.[10] However, the Commission became disturbed when the PIPE II experimental proposal became integrated with a DOH prepaid health plan project (PHP), which provided that rates be approved by a Rate Review Board with five public members appointed by the Director of Health rather than the Commission.[11]

The DOH had opposed Commission involvement in PIPE II, and PIPE project staff viewed the DOH's political support as essential if the project was to receive continued funding. They also felt that participation of the state Medi-Cal program in the process of rate determination was necessary for the project to succeed. PIPE project staff therefore chose to work with the DOH as a means of assuring the continuation of its project. Several Commission members said that

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[10] *Prospective Incentive Payment Experiment, Phase I.* Final Report June 30, 1976, Hospital Educational Foundation of California, Inc., p. 8. The project developed a procedure to forecast community demand for hospital services, suggested methods for phasing out excess capacity considering closure of facilities and bed/service reductions, merger and sharing of facilities, and a budget and rate review methodology.

[11] The Phase II PIPE proposal for a three-year budget and rate review experiment in the Sacramento/Sierra Health Service Area involved all 25 nonfederal acute care hospitals and all payors in the region including government. It was integrated with a DOH proposal providing $5.3 million to develop actuarial approaches for the establishment of Medi-Cal prepayment rates for prepaid health plans (PHPs). The federal project called for two demonstrations: one involving closed panel prepayment and another in the Sacramento area for open panel prepayment. The proposed project also involved the participation of physicians in the open panel project through the Medical Care Foundation of Sacramento. The Rate Review Board would hold hearings and make rate determinations in a manner similar to a public utilities commission.

PIPE II was in conflict with CHA and Commission policy, both of which called for rate review by a body independent of the state's major purchaser of care. CHA reaffirmed its support of the Commission as the appropriate body to regulate rates statewide; however, CHA trustees felt that a trial program was necessary before statewide application, and that working with the DOH on this basis was acceptable and perhaps necessary to assure the viability of PIPE II.[12]

The DOH endorsed the PIPE II project because a single rate review group could serve both the DOH's prepaid plan project and the PIPE II experiment. Nor did the DOH see any conflict between its own SSA project and PIPE. Its endorsement letter said, "The two efforts would be complementary . . . [since] the Department staff would concentrate on comparative evaluation of rate-setting methodologies, while the strength of the PIPE project lies in its readiness to apply a scientific methodology in vitro."[13]

It was estimated that project Medi-Cal and Medicare costs would increase in the short-run while payments by other payors would decrease. The DOH agreed to participate in PIPE on condition "that State funds are not at risk because of the application of this methodology." It noted informal indications from SSA and SRS that they would assume the risk of increased Medi-Cal expenditures and said they would have to agree to do so formally before the state participated.[14]

When the availability of additional federal funds to offset state costs became doubtful, the DOH tried to get the Department of Finance to support PIPE II, since increased state funds would be required from the state Medi-Cal program to provide equal payment to all purchasers. The Department of Finance countered with several questions: Why should the state be involved in overall cost control?

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[12]Commission Minutes February 10, 1976 and April 6, 1976; interviews with CHA staff; CHA Board of Trustees Minutes March 18, 1976.

[13]Letter from DOH Director Lackner to Henry Zaretsky of CHA dated June 4, 1976.

[14]Ibid.

Why not merely continue the present controls over Medi-Cal? How would PIPE reduce redundant facilities and services? If services would be cut back, why are hospitals willing to accept such controls? At a meeting held to consider the project's financial implications for the state, PIPE staff explained that some facilities would be forced to close owing to HSA recommendations and cost ceilings imposed on them. It was estimated that increased state General Fund cost for the project would range from $7 to $12 million over two years. The DOH estimated that the gap between Medi-Cal and other payors would be closed over a five-to-ten-year period. Within three to five years the Medi-Cal rate of increase would be offset by mandatory cost savings. The rate of increase in Medi-Cal would be a negotiated amount.

Health and PIPE staff argued that state costs bear a relationship to total cost growth, and would continue to escalate with no overall program controls. The DOH argued that the state was responsible for controlling both overall costs and Medi-Cal costs, and that in the long run this would provide a more equitable system and reduce state costs. The Department of Finance estimated that equal payment would cost the state $100 million the first year. PIPE staff indicated that hospitals were willing to participate to get an equitable reimbursement system in place that would be predictable and allow them to manage their resources more efficiently.[15]

The general position of the Department of Finance was that the state would pay equal rates only if overall cost containment were guaranteed. It was up to the DOH to work out an acceptable approach.[16]

PIPE efforts to work with DOH ran aground when the physician component (represented by the Sacramento Medical Care Foundation) dropped out of the state's prepaid health plan project. Also, PIPE

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[15]Memo from Robert Murch to Commission Chairperson Phyllis Smith, August 4, 1976, and interviews with Department of Finance, DOH, and CHA staff.

[16]Ibid.

staff were informed by SSA officials that, contrary to an earlier expressed position, the SSA *would not* spend more money for PIPE than they were spending under Medicare.[17] In addition, when the DOH project came under fire in the legislature, SSA officials said they would not fund PIPE II unless the Department's project was approved.[18]

The Administration's Position

After SSA received competitive applications from two state agencies, SSA officials requested that the state support one or the other. Because of its authority to approve, disapprove, or modify grant proposals submitted to federal agencies, the Department of Finance evaluated the two proposals and on July 9 formally endorsed the DOH project, opining that its "formula approach is more objective, less administratively cumbersome, and should be pursued in preference to the Commission's budget and rate review proposal."[19]

The Department of Finance's staff analysis concluded that the DOH's formula approach would "over the long run . . . provide a methodology to control rates, as opposed to simply approving them as the Health Facilities Commission proposal would do."[20] Also, according to Finance, even though the DOH system would require the development of a complex econometric model, the system would be easier to administer. Finance also disliked the fact that "industry representatives are the only active participants in Commission activities and therefore provide the major source of input for the Commission."[21]

After hearing the Department of Finance staff recommendations, the Commission suggested that the three projects proposed to SSA be combined: The Commission would perform budget and rate review, and

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[17] Interviews with CHA staff.

[18] Ibid.

[19] Memorandum from Al Loeb, Program Budget Manager, Department of Finance, to Commission Chairperson Phyllis Smith, July 9, 1976.

[20] Department of Finance unpublished staff analysis.

[21] Ibid.

a five-member council appointed by the Director of Health would determine the Medi-Cal payment level. These changes would be amended into the PIPE II proposal and the separate DOH proposals would be dropped. While discussions were being held about the proposal consolidation, the Department of Finance announced its decision to endorse the DOH project. The Commission Chairperson dubbed that action "a breach of good faith" and one not in the interest of the state, which could best be served by a unified state approach eliminating developmental projects in favor of an immediate experimental program.[22]

Department of Finance staff interviewed maintained their evaluation was objective and not swayed by the DOH or the Health and Welfare Agency. Other observers maintained that the Department of Finance was not favorable to independent Commission's making decisions affecting major state costs, preferring that this be done by an executive branch agency subject to influence or control by Finance. Also, since Finance was more concerned with saving state funds and simple administration than assuring equity for hospitals, they favored a formula approach that hospitals looked upon as arbitrary.[23]

On September 1, 1976, the SSA formally notified the Commission that its proposal was eliminated from consideration, citing three substantive reasons.[24] In the Commission's view, however, the key element in SSA's decision was endorsement of the DOH project by the Department of Finance. The DOH was notified in October that its project was approved (but federal funds were never allocated). The

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[22]Letter from Commission Chairperson Phyllis Smith to Director of Finance Roy Bell, July 21, 1976.

[23]Interviews with Commission, health industry, DOH, and Department of Finance.

[24]They were that it (1) failed to show statutory authority or commitment of providers to participate; (2) relied too heavily on subcontractors rather than building in-house capability; and (3) had "too liberal" an exceptions process, which seemed to negate its cost containment potential. Letter to Commission September 1, 1976 from SSA contracting officer.

administration's decision to support the DOH project became entwined with its decision to phase out the Commission. The legislature disapproved both decisions.

ADMINISTRATION POLICY ON PHASING OUT THE COMMISSION

The position of Finance toward the Commission was influenced by its recommendation concerning the SSA study. By concluding that the DOH's formula-based approach was superior to the Commission's approach, Finance also implied that rate setting should not be a function of the Commission. In that case, the Commission's raison d'être came into question, especially since it enjoyed little support from the Brown administration and the hospital industry was working with the DOH.

A review of the Commission was requested by internal management, in line with the Governor's policy enunciated in a July 10, 1976 memorandum questioning the continuation of programs that had outlived their usefulness.

Finance Report Recommendations

The Finance Department, in an October 1976 report, recommended:

1. The Commission's accounting and disclosure be transferred to the DOH on July 1, 1977.

2. The Commission's functions for long-term care facilities be transferred on December 31, 1978, after completion of reports from those facilities.

3. A separate appeals body be set up if rate-setting legislation were enacted.[25]

DOH officials were pleased by the Finance report. Some felt it was a good thing to let Finance become the prime advocate for transfer

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[25]*California Health Facilities Commission*, State Department of Finance Program Evaluation Unit, October 1976.

of the Commission's functions, especially since the DOH was under increasing attack from the legislature and Finance recommendations might receive a mjore sympathetic ear.

The Finance report was based on a review of Commission activities and interviews with the Commission, the DOH, the health industry, and the Assembly Office of Research. It further found that:

- The Commission's accounting and disclosure system, developed with the cooperation and active participation of industry, could "prove to be a forerunner for the entire United States." Once developed, however, the system would be essentially "mechanical," and a number of agencies could maintain it.

- There is overlap and competition between the DOH and the Commission which could become more serious if the Commission role were expanded.

- There has been no affirmative legislative response to the Commission's effort to expand its programs in the field of rate regulation or Certificate of Need.

- "Many people believe that the Commission is too sympathetic to the industry," but that the industry was cooperating with the DOH on PIPE II, leaving the Commission "without an industry advocate."[26]

Finance also based its recommendations on "the need to avoid fragmentation in the areas of rate setting an- Certificate of Need,"' with Finance assuring that rate regulation would "most likely be given to the Department of Health since it now has extensive rate-setting responsibility for Medi-Cal."[27]

The Department of Finance recommendations were almost identical to those made in January 1976 by the Little Hoover Commission and a DOH internal position paper. The Little Hoover Commission had recommended abolition of the Commission and transfer of its duties

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[26]Ibid., p. 26.

[27]Ibid., p. 31.

to the DOH. A June 1976 DOH position paper pointed out conflicts between the DOH and the Commission concerning control of data, Certificate of Need, and rate regulation. It noted conflict between the two agencies' SSA proposals, stressing that the Commission's proposal was "virtually identical" to that of the CHA. It also noted that the Commission's economic stabilization legislative recommendations were "dead."[28]

Administration Position

The Governor decided to favor phasing out the Commission in 1976 on recommendation of both the Health and Welfare Agency and the Department of Finance. The reasons were that the Commission had completed the job of hospital disclosure, the DOH could perform its functions, and the Commission was industry-dominated. Since the administration had not yet formulated its policy on rate regulation, it would be best to eliminate this body. If it were later decided that a Commission form would be best for implementing policy, the administration could begin afresh with a new consumer-oriented body.[29]

LEGISLATIVE ACTION

After the federal government decided to award a contract to the DOH, and Governor Brown announced the intended phase-out of the Commission, it would have been reasonable to assume that the DOH would implement the SSA project and that the Commission's days were numbered. However, the legislature intervened and subjected both the DOH and Commission projects to review.

The Legislative Analyst recommended against transferring the Commission's functions to the DOH. His report challenged the Department of Finance's conclusion that the Commission had substantially

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[28] *Commission on California State Government Organization and Economy*, p. 353, and DOH Staff Report, June 28, 1976.

[29] Interviews with administration officials.

accomplished its statutorily mandated duties, noting that the law required the Commission to develop "one uniform comprehensive data system which takes into account the data requirements of all state programs" (Health and Safety Code, Sec. 441.16(c)).

Moreover, the Analyst questioned "the ability of the Department of Health to administer additional responsibilities competently in the area of health facility data collection. The Department of Health's record in administering its present health facility duties is not an impressive one."[30]

The legislature became involved in review of the SSA projects by the authority of the Joint Budget Committee to approve a waiver of the 30-day waiting period required under Sec. 28 of the Budget Act. Approval is required before federal funds received by the state can be expended. By convention, items disapproved by the Joint Budget Committee under this procedure are referred to the appropriate fiscal committees of each house for action as part of their regular budget review process.

Action was taken to deny the waiver because of the Legislative Analyst's opinion that the proposed project "is a major policy issue which should receive full legislative review" since it "could be a significant step toward prospective rate setting for all hospitals." The Analyst also questioned whether the DOH was the appropriate agency to develop this system since the Commission had also proposed a project. The Analyst recommended that both projects be reviewed.[31]

Several legislative committees thereupon chose to hold special public hearings on the competitive proposals so that an early decision could be made. The SSA had told state officials that delay would jeopardize the availability of federal funds.

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[30]Report of the Legislative Analyst on the 1977-78 Budget, p. 669.

[31]Letter from Joint Budget Committee Chairman Donald Grunsky to Director of Finance Roy Bell, November 29, 1976, and letter from Legislative Analyst A. Alan Post to Joint Budget Committee Chairman Donald Grunsky, November 24, 1976. According to persons interviewed, Commission and CMA staff encouraged the staff of the Legislative Analyst to raise questions about the DOH project.

The Commission Response

The Commission chose to take its fight against the DOH proposal and against the administration-recommended budget transfer to the legislature.

The Commission criticized the Department of Finance report as "inconsistent and contradictory," and pointed out many technical errors.[32]

In defending its relationship with the health industry, the Commission said, "More can be accomplished by way of a cooperative relationship rather than an adversary one."[33] It pointed out the inconsistency of criticizing the Commission for being too sympathetic to the industry and then by implication criticizing it as lacking industry support on the grounds that the CHA chose to work with the DOH on PIPE II.

In response to charges of duplication of effort with the DOH, the Commission cited its legal authority to develop an economic stabilization program, conduct special studies, and develop uniform health facility data. It reiterated its position that the DOH, as the state's major purchaser of care, should not regulate rates. Finally, the Commission challenged the view that its major job of setting up an accounting, reporting, and disclosure system was done. It said that policy decisions were necessary covering disclosure and reporting and accounting system modifications. It reiterated the need for an independent body to collect, analyze, and publicly disclose hospital financial data.[34]

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[32]Commission response to Department of Finance Evaluation, January 10, 1977.

[33]Ibid., p. 3.

[34]Enclosure with letters to Senator Gregorio and Assemblyman Torres, February 25, 1977.

The Commission's Legislative Strategy

The Commission refrained from soliciting industry support before the legislature because it was already being criticized for being too close to the industry. However, it solicited "quiet" support from interested organizations.[35]

In May 1976 the Commission hired a legal counsel with extensive prior experience as a legislative staff member, who was to handle relationships with the legislature. He helped develop a legislative strategy to keep the Commission afloat and to expand its duties to include disclosure of hospital budgets and rates as proposed in the Commission's 1977 Annual Report. To achieve these objectives, the Commission publicized its activities to legislators and sought to get legislation introduced, hopefully by the Chairman of the Assembly Health Committee, expanding its powers and duties. The Commission also lobbied against the DOH's SSA project and administration recommendations to phase out the Commission.

The Commission Chairperson and legal counsel met with members of health policy and fiscal committees of both houses. Legislators were given summary financial data on hospitals in their districts and were told about the Commission. Most legislators were found to be unaware of the Commission. However, there appeared to be little support for the administration's recommendation to transfer Commission functions to the DOH, and some legislators commented negatively on the DOH's performance.[36]

Particular efforts were made to gain support from Assembly Health Committee Chairman Keene. He had asked that the Commission draft legislation to accomplish budget and rate review and budget and rate disclosure, and develop alternative approaches to changing Commission membership to make it more consumer oriented. Keene's bad experience with the DOH and the administration on AB 4001 (his

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[35] Industry interviews.

[36] Interviews with Commission staff.

Certificate of Need bill) and concern about the DOH's poor leadership and performance helped make him a supporter of the Commission.[37] When the SSA project became a legislative issue, Keene supported the Commission's position and helped to defeat the DOH's project. He later introduced legislation (AB 1156) to reorganize and expand the Commission's role (see Chap. 7).

Department Strategy

The initial strategy of the DOH was to neutralize the influence of the Commission by gubernatorial appointments of persons who supported the DOH project and administration policy. Despite Health and Welfare Agency support for this position, the Governor's office did not make these appointments prior to the legislative hearings.[38]

Legislative Hearings

The competing proposals were the subject of hearings by the Senate Health and Welfare policy committee, the Senate Finance Health and Welfare Subcommittee, the Assembly Ways and Means Health and Welfare Subcommittee, and the Joint Budget Committee, all within two weeks. The Senate Finance Subcommittee voted to approve the DOH project while the Assembly Ways and Means Subcommittee and the Joint Budget Committee voted to disapprove it.[39]

The Commission argued again that the DOH, as a major purchaser of care, should not regulate rates, that such delegation of authority would result in a conflict of interest, and that legislative approval

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[37] Keene discussed his interest in sponsoring rate regulation legislation with the Commission at its January 20, 1977 meeting.

[38] Interviews with DOH and Health and Welfare Agency staff.

[39] Because the author attended all these hearings, the following description is based on personal observation. The Senate Health and Welfare Committee met on February 23, 1977. The Senate Finance Subcommittee met on February 24 and March 1, 1977. The Assembly Ways and Means Subcommittee met on March 1 and March 2, 1977, and the Joint Budget Committee on March 2, 1977.

of this project was an implied commitment to future rate setting in the DOH. The Commission urged the legislature to decide by law who sets rates and not leave this determination to an administrative agency, and argued that the Commission was more competent than the DOH to regulate rates. It had for many years been studying rate regulation under legislative authorization and had specific authority to do "special studies" in this field. Rate regulation could better be done by a public commission operating in the open, rather than by the DOH, which had been criticized for secretive and arbitrary rate-setting decisions. The Commission also had authority to accept such federal delegation of rate regulation duties as might be imposed under some form of rate regulation to be proposed by the Carter administration. There was questionable need for further study by the DOH, which had hurriedly developed a study that would duplicate activities already being conducted by the Commission (e.g., grouping of hospitals and studies of costs and productivity).

Commission representatives argued that the formula approach proposed by the DOH did not adequately recognize differences between hospitals and was not sensitive enough to community needs. Also, they said that under the DOH project the state was not obligated to pay the same rate as other purchasers, and low rates--most likely based on current Medi-Cal reimbursement--would downgrade the quality of hospital care. In their view, the need for a speedy decision about a federal contract should not force a legislative decision on this matter, especially since the DOH received the award after the administration, apparently on a political basis, chose to support its proposal over that of the Commission.

The DOH argued that providers and provider-oriented public members dominated the Commission, and that the question for the legislature to decide was whether they wanted provider-oriented or taxpayer-oriented decisionmaking. They said Commission bias toward providers was suggested by the fact that the Commission proposal "mirrored" that of the CHA PIPE project. They urged that regulation by the Commission would fragment health policymaking and that this authority

should be part of the executive branch administration of all health programs. They criticized the Commission's budget review approach as "cumbersome" and less likely to result in cost containment than that proposed by DOH. Moreover, even according to Commission representatives, a decision on this project would not bind the legislature to give rate regulatory powers to the DOH. It would permit the state to participate in a national experiment with other states to test different rate-setting approaches.

In addition, they said that the SSA had rejected the Commission's project and accepted the DOH's on the basis of a technical review. The choice for the legislature was to support the DOH or have no project. Finally, they pointed to important methodological similarities between the two projects, implying that the Commission was magnifying small differences between the two. Both projects called for development of (a) a grouping system; (b) a hospital cost model; (c) forecasting techniques; (d) units of payment; (e) budgets; and (f) administrative procedures for rate setting and appeals.[40]

Throughout the hearings the DOH was on the defensive. In the Senate Health and Welfare Committee, one Senator asked why the DOH wanted more functions when it had so many problems carrying out its present ones. Another Senator commented that the DOH's current reimbursement policies under Medi-Cal would eliminate "mainstream" hospital care for the poor and force them into county hospitals. A third wondered if the DOH might be reluctant to set equitable rates for all payors, since its primary interest was to hold Medi-Cal rates down.[41]

Before the Senate Finance Health and Welfare Subcommittee, questions were raised about the desirability of committing the state to a formula rate-setting approach and about the implied commitment

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[40]According to one DOH source, operational differences between the formula and budget approaches are less than the conceptual differences. He said the differences are matters of degree, not kind. The budget approach must begin with formula-like "budget screens," only exceptions are negotiated. The formula approach must also allow for negotiation of exceptions.

[41]Hearing held February 23, 1977.

that DOH would set rates in the future. One Senator commented that "Going with the Department is like putting on one leg of a pair of pants. You don't *have* to put on the other leg but you're already into it."

Assembly Ways and Means Committee members also questioned the department's "conflict of interest" and "poor track record that make us suspicious of its responsiveness to legislative interests or requirements."

Assemblyman Keene, Chairman of the Assembly Health Committee, also announced his opposition to the DOH project in two letters to the Assembly Ways and Means subcommittee chairman. He opposed giving rate regulatory authority to the DOH, viewed approval of this project as a potentially irreversible step in that direction, and questioned the use of a formula approach to rate setting. He also announced his intention to introduce legislation establishing rate-setting authority in an independent commission, and expressed concern that legislative action supporting rate setting in the DOH might "pre-empt" legislative deliberations on these issues.[42]

Some legislators questioned the desirability of a provider-oriented body like the Commission undertaking the project. The Commission Chairperson said she personally favored an all-public-member Commission. Since there was no "live" Commission project, this concern never became a key factor in legislative decisionmaking.

The DOH project was reluctantly approved by the three-member Senate Finance subcommittee. Its chairman, Senator Arlen Gregorio, felt that the state should participate in and learn from the national study. However, he announced introduction of a resolution expressing the sense of the legislature that this project should not commit the state either to future administration of rate regulation by the DOH nor to any particular method. He noted "grave reservations" about the DOH conducting the project because of its "conflict of interest"

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[42]Letters from Assemblyman Barry Keene to Assemblyman Art Torres, February 28 and March 2, 1977.

as the largest purchaser of services. The other Senator who finally supported the project was opposed to rate setting in the DOH but went along with the study only with the understanding that "this endorses nothing" (i.e., a future rate-setting role for the DOH).

The Assembly Ways and Means Committee took action to disapprove state funds for the project. The Joint Budget Committee took action not to change its previous position refusing the Department of Finance's request for a 30-day waiver; the effect was to prevent allocation of the federal funds until action by the separate fiscal committees of each house as part of their regular budget review process. This in effect killed the project.

Reasons for Defeat of the SSA Project

Legislators and staff who participated in the deliberations said the prime reason for the defeat of DOH's SSA project was the legislature's lack of confidence in the DOH and its leadership, stemming from several causes: the feeling that "the department is too big and poorly managed to be given added responsibility"; continuous complaints from constituents; poor experience with rate-setting by the DOH; the DOH's poor performance before the legislature concerning Certificate of Need and abuses in prepaid health plans and other matters; lack of health policy direction; and continuing problems with management of state hospitals.

Position of Interested Organizations

No interest group took a public position before legislative committees for or against the DOH's SSA project. UHA representatives lobbied against it, however, and a CHA spokesman pointed out to some Ways and Means subcommittee members that the DOH project violated CHA policy calling for separation between the regulator and the purchaser of care, leaving the clear impression with some key members that CHA opposed the project. The earlier CHA action to work with the DOH apparently provoked enough opposition from the Commission and within

CHA to prompt a more strict adherence to traditional CHA policy, even at the risk of sacrificing federal funding for PIPE.[43]

The CHA, UHA, and nursing homes (CAHF and CAHA) supported the Commission's continued existence and opposed transferring its duties to the DOH. They did not issue public statements of support or testify publicly before legislative committees. Sensitive to criticism of "industry domination," both health care industry leaders and the Commission wanted to avoid lending greater credibility to this viewpoint.[44]

In letters to the fiscal committees of both houses, the Commission urged acceptance of the Legislative Analyst's recommendation that the Commission be continued. It argued further that transfer of the Commission's responsibilities to the DOH by the budget process was inappropriate and that such a change should be accomplished by statute. If the budget were transferred and the law not changed, "the Commission would be in the impossible position of being required to do a job for which it was not properly funded."[45] Both fiscal committees restored the Commission's budget.

The Aftermath

According to one news report the action by the Assembly Ways and Means Committee killing the DOH project "provoked consternation on the part of officials of the State Department of Finance and Senator Arlen Gregorio, the Chairman of the upper house Health and Welfare Committee, who had recommended the study proceed." Finance officials

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[43]Interviews with UHA and CHA staff and with members of the Assembly Ways and Means Health and Welfare Subcommittee.

[44]Interviews with health care industry.

[45]Commission letters to Senator Arlen Gregorio and Assemblyman Art Torres, February 25, 1977.

were upset with the legislature because it rejected their recommendations, and with the Commission because it argued that the study was unnecessary even after having submitted its own proposal.[46]

The legislative vote of "no confidence" in the DOH was a critical event in the history of the Commission. The defeat of the DOH's SSA project delivered a clear signal to the administration that the DOH was not acceptable as a rate regulator. The legislature's fiscal subcommittees approved the Commission budget and ignored the administration's recommendation that the Commission be phased out. The Commission had won its battle for survival. The Governor thereupon made appointments to the Commission.

But every battle inflicts some casualties. The Commission's Chairperson, who was viewed as the Commission's "hundred-dollar-a-day lobbyist" against the administration, was not reappointed, and the new Commission fired the Executive Director.

There were some last-minute efforts to resurrect a state rate-study project. Some DOH staff favored legislation that would authorize a rate experiment by the Commission. This position was accepted by the Health and Welfare Agency but rejected by the Department of Finance, which contended that nothing should be given to the Commission. The suggestion was rejected.

A second approach was to work with CHA in amending the PIPE project to establish a Rate Review Board in the Health and Welfare Agency and include staffing for DOH personnel as part of this revision. This approach was rejected by CHA since it violated CHA policy that the purchaser of care and the rate regulator be separate. With the defeat of the DOH project, federal funding for PIPE was not approved.

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[46] *Sacramento Bee*, March 8, 1976.

The action by the legislature to kill the DOH project was unusual; it had not acted to return federal grant funds since the early 1950s, when it decided against accepting civil defense funds.[47]

SUMMARY

After the election of Governor Brown, the Commission faced an increasingly hostile political environment. The Brown administration did not support it. Industry feared for its survival because the Governor failed to make appointments to it, and then worked with the DOH rather than the Commission to promote its own interest in the PIPE project. The DOH was competing with the Commission for regulatory authority on a number of fronts. Finally, the administration sought to eliminate the Commission, which thereupon fought the DOH's SSA study and won in the legislature.

On March 2, 1977, two legislative committees, in an unusual action, refused to allow the DOH to conduct a study using SSA funds to help develop methods to set hospital rates. This action was a major event in the history of the Commission. It not only was an important defeat for the DOH in its quest for rate regulatory authority, but it also stimulated action to keep the Commission alive.

The issues raised by the three proposed SSA projects illustrate the complexity of developing a politically acceptable rate regulatory approach. Industry insistence that the government pay the same rates as other purchasers, and support for budget and rate review and approval of individual hospital budgets, imply substantial increases in government program costs. Government interest in keeping its cost down militates against acceptance of equal payment and in favor of a tight formula constraining cost growth--both unacceptable to industry.

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[47] Interviews with Roy Bell, March 1977, and discussion with Legislative Analyst A. Alan Post. A number of legislators have become increasingly concerned about the impact of federal grants on state policymaking. Some have advocated that all these funds be subject to legislative appropriation.

Federal legislation had the desirable effect of stimulating state action to experiment with rate-setting approaches. Unwillingness of federal officials to involve themselves in political choices between state agencies had the probably desirable effect of leaving such choices to state officials primarily responsible for administration of state functions.

POSTCRIPT: THE NEW COMMISSION

On March 9, 1977, Governor Brown made 9 long-awaited appointments to the Commission, bringing its membership to 13 and giving public members a majority for the first time (7 of 13). He replaced two public members whose terms had expired, including the Commission Chairperson. Two other appointees were continued as holdovers (the physician president of CMA and a health insurance representative), and two other members had unexpired terms (a hospital administrator who is president of the American Hospital Association and a former prepaid health plan manager). An additional public member was appointed soon after the 9 new members were announced, bringing the Commission up to 14 members, one less than authorized by law. The Governor has not yet appointed an executive officer of an investor-owned hospital.

Most of the new appointees were nominated by the DOH, but a few were named by the Governor's office. Apart from their other qualifications, most were selected according to their willingness to support administration policy, including a phase-out of the Commission if the administration chose to pursue this course. They were requested to take no position on the future of the Commission until administration policy was developed, and to evaluate staff carefully and consider making changes in top staff.[48]

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[48] Confidential interviews.

After the forced resignation of its Executive Director, the Commission hired an Acting Director, the former CHA liaison to the Commission, who had long advocated public utility regulation of health facilities and had resigned from CHA after he saw that the industry no longer was moving in that direction.[49]

The new Commission differs sharply from its predecessor. First of all, it is younger. The average age of the nine members appointed on March 9, 1977 is 35 (their ages range from 28 to 52). The average age of previous Commission members was about 60. Two new appointees were associated with health law advocacy groups (one is now head of program review for a Health Systems Agency). The vocations of the seven other new appointees are: dental director of a family health center; clinic fiscal officer; university administrative analyst; university economist; attorney in private practice; accounting firm president (consultant to CAHF); and vice president of a private hospital management company.[50] Health industry groups were not consulted on these appointments as they had been during the previous administration. No previous Commission member had worked for a consumer advocacy group or clinic.

The new Commission has sought to involve consumer organizations in its activities. For example, it has invited representatives of consumer organizations to present their views at Commission meetings. Several new Commissioners have strongly supported dissemination of disclosure data to consumer organizations and HSAs. The Commission's proposed budget calls for having a consumer liaison to work exclusively with these groups, and a Public Information and Consumer Outreach Committee has been formed to work with consumer organizations.[51] A consultant was asked to review Commission policy issues of interest

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[49]Hospital industry interviews.

[50]Governor's Press Release No. 59, March 9, 1977.

[51]See Minutes of Commission Meetings, April 18-19 and June 13, 1977.

to consumers and present recommendations on how the Commission might represent consumer interests. The consultant responded with numerous recommendations, many of which involved expanded Commission authority and cooperative efforts with other agencies.[52]

In contrast to its predecessor, the new Commission expects to be a strong influence in the formulation of Brown administration health policy and legislation. Its policy statement, adopted by an 8 to 4 vote over the opposition of industry members, calls for

- A comprehensive system of regulation . . . which may have the general characteristics of public utility regulation . . . [requiring] a coordinated State program with an independent State Commission in a central coordinating role;
- Extension of financial disclosure "in a manner to command public attention;"
- Expansion of Commission authority to review and approve health facility budgets and rates;
- The State to "follow the Governor's lead in taking a bold new view of the relationship between the health facility industry and State government."

In contrast to its "holdover" predecessor, the new Commission appears to be part of the Brown administration "team." However, the Commission's role is still circumscribed by law and limited to disclosure, study, and recommendation. Recent action by the legislature to kill the Governor's proposed rate regulation program suggests the future difficulty of gaining political acceptance for its proposed new mission. To surmount the apparent legislative unwillingness to act on rate regulation proposals expanding its powers, the Commission is working in cooperation with Assemblyman Keene to develop a cost containment initiative to qualify for the November 1978 ballot.

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[52] See "The Cost of Health Care in California: The Consumer Interest," prepared for the Commission by Paul F. O'Rourke, M.D., M.P.H., August 15, 1977, and contained in *Commission Minutes*, August 22 and 23, 1977.

Chapter 10
SUMMARY, IMPLICATIONS, CONCLUSIONS

SUMMARY

Seven themes pervade this study of California's efforts to regulate health facility cost growth. They are indicated in this chapter by bulleted italics. The first is:

- *The response of a diverse and sophisticated hospital industry and other allied provider groups to changing cost-containment and political pressures in California.*

The Commission was initiated by hospitals, with the acquiescence of organized medicine, largely to prevent a more extreme and unacceptable form of regulation and to assure that provider interests were represented in any developing regulatory scheme. The Commission was given a narrow and technical charter consisting principally of a mandate to develop a uniform accounting, reporting, and disclosure system for health facilities. It did not have power to regulate hospital costs or charges directly and implementation of its responsibilities required specialized knowledge of hospital financial management and statistics. With this circumscribed charter, its performance could be tested under conditions permitting a significant degree of industry influence while the industry sought to determine whether further steps toward regulation were necessary or desirable.

The hospital industry influenced the Commission in several ways; it provided technical assistance to the Commission in developing the reporting system, and political assistance to help the Commission expand its authority. With provider support, the Commission's functions were expanded to allow it to (1) accept delegation of federal price control authority, should this be forthcoming, and to replace federal price controls under Phase IV of the federal economic stabilization

program with a state-level economic stabilization program; (2) regulate the financial affairs of long-term-care facilities in a manner similar to that for hospitals; and (3) collect nonfinancial health facility data. From the point of view of health providers, it was far better to work with and expand the duties of a friendly state commission, designed by the industry and with industry representation, than to see such powers exercised by either a far-off unresponsive federal government or a state Health Department more concerned with saving Medi-Cal dollars than protecting the economic well-being of health facilities.

Some within CHA expected and hoped the Commission would grow into a rate regulatory agency resembling a public utilities commission for the hospital industry that would assure the financial stability of the industry while subjecting it to acceptable constraints. They foresaw the advent of national health insurance accompanied by broad government controls over the health sector. They believed it would be better for the industry to help fashion comprehensive controls than live with "piecemeal" regulation developed by government purchasing agencies without industry participation. Support for this view was stimulated by the imposition of federal price controls in 1972, which many in the industry regarded as arbitrary and unjust; state regulation with industry involvement would be more acceptable. Reflecting this view, in 1973 CHA initially supported Reagan administration legislation (SB 413) that would have reposed Certificate of Need authority with the Commission and delegated federal rate regulatory controls to it. However, the legislation failed after opposition by CMA and other hospital groups; CHA itself later opposed the bill when Kaiser was exempted from its Certificate of Need provisions. The industry was unwilling to allow prepaid plans to escape from market entry control. A public-utility form of regulation combining Certificate of Need and rate regulation was favored by the 1974 CHA Task Force on Government Regulation, which included representatives of major hospital groups. The Task Force was willing to accept comprehensive regulation *if* hospital financial requirements were to be met; according to its 1974 report, state regulation should

be based on (1) assuring reasonable profit for investor-owned facilities, and surplus for nonprofit organizations; (2) protecting the overall economic well-being of the industry; (3) assuring equal payment for the same service by all purchasers of care; (4) having an independent commission separate from the state's major purchaser of care administer the program; and (5) arranging review and approval of individual hospital budgets in accordance with administratively established guidelines.

Although the CHA Task Force recommended that rate review, planning activities, and Certificate of Need controls be placed in the Commission, CHA trustees, after opposition from CMA, UHA, and other groups, favored separation of these functions and proposed that planning activities and capital expenditure controls be placed with the Advisory Health Council.

Two events in 1974 influenced the policies of health provider groups: Federal price controls were lifted and a new Democratic governor was elected. Following those events, hospitals were unwilling to favor further expansion of the Commission's power to regulate rates. When the Brown administration took office in 1975, CHA did not support legislation to implement the Commission's economic stabilization program nor did it introduce legislation to implement its own policy statement on government regulation. In its October 1975 testimony before a legislative committee, the CHA argued that rate regulation should be considered later, only *after* disclosure. Apparently, after having been subject to distasteful federal controls, hospitals preferred no controls at all. Moreover, the policies of the new Governor on matters of health facility regulation were not yet fixed, although his initial appointment of consumer advocates gave hospital leaders cause for alarm.

According to industry sources, CHA executive leadership was so closely identified with Dr. Earl Brian and the Reagan administration that they had major problems relating to the Brown administration. After Governor Brown was elected, the CHA sought new executive leadership, partly to improve its relations with the new administration.

A new president-designate was elected who served alongside past leadership during 1976 and sssumed his position in July 1977. Some hospital industry observers have suggested that the bifurcation of CHA top executive staff, sparked by the change in gubernatorial administration, weakened CHA's ability to lead the hospital industry.

The transition in CHA executive leadership, combined with the adversary approach toward health providers that some industry spokesmen viewed as characteristic of the Brown administration, and with the dropping of federal price controls, apparently led to the position that hospitals themselves should not initiate rate regulatory programs. According to one industry leader, "During this period [i.e., early years of the Brown administration] the philosophy [of CHA] has been one of reaction rather than action as a political strategem."

The seeming cool indifference of the Brown administration toward the Commission and toward rate regulation initially frustrated CHA, and Brown's failure to make appointments to the Commission gave CHA doubts about its survival. To preserve PIPE, the CHA-sponsored experimental rate regulatory project, the CHA reversed its previous stand against cooperation with the state's major purchaser of care, the Department of Health. It began to work with the DOH, substituting an independent rate body appointed by the Health Director for the Commission in its project proposal. This irked some industry leaders, who felt it violated long-held industry principles.

In 1977, the CHA leadership felt the organization had probably erred by previously incorporating the DOH into the PIPE project, and sought to reinforce previous CHA policy favoring separation between payor and regulator. CHA lobbied subtly in the legislature against the DOH's Social Security Act rate study project. They made some key legislators aware that CHA did not favor the DOH's project, even though negative action by the state on the DOH project could negatively affect federal funding for the CHA-supported PIPE project.

In 1976, in what a number of observers called a major policy shift away from previous support of rate regulation, the CHA opposed the recommendations of the Commission's Task Force on Short and Long-Range

Objectives. The Task Force was set up to develop a more specific methodology to implement the Commission's economic stabilization program. It proposed that an aggregate expenditure target (ACIT) be set as a basis for reviewing facility budgets, and supported the phasing out of unneeded facilities and services to achieve cost containment.

The CHA position was taken even though (1) CHA staff participated heavily in the Commission's work; (2) the same principles were contained in the CHA-supported PIPE II project; and (3) the recommendations emanated from a subcommittee headed by a CHA past president who was the AHA's chairman-elect. According to one industry observer, this was an early prime example of CHA's "digging in their heels" against government regulation and "acting like CMA." A more recent example is the strong CHA opposition to Brown administration-backed rate regulatory legislation.

- *The diversity of California's health care industry, as reflected in the positions of provider interest groups on cost containment issues.*

Provider groups representing hospitals and medicine have recognized their common interests in matters affected by government regulation, and generally consult each other on policy or administrative matters that affect their vital interests. They have perceived the value of a united front in attempting to influence governmental action. Efforts are made to compromise divergent views before they may become the subject of public dispute and therefore possibly weaken their collective political strength. Organized medicine has usually been consulted by CHA on major regulatory issues, since CMA opposition could spell defeat for hospital-supported measures. For example, the CHA proposal to establish the Commission was discussed with CMA leaders before its introduction, and compromises were negotiated before the proposal was finalized. However, hospitals and medicine have not always agreed; sometimes their positions have clashed.

For example, the AHA Perloff Committee Report, drafted in 1971, recommended creation of regional health care corporations; it was not well received by organized medicine, and some hospital administrators who supported it reportedly lost their jobs because of opposition by hospital medical staff. According to one interviewee from the health industry,

> . . . hospitals and medicine have been quietly snarling at one another for some time. In the view of some physicians, hospitals are hotels and doctors provide care. Hospitals, on the other hand, feel they provide care and the physician must be part of a rational system of controls over how that care is provided.

The interests of organized medicine and hospitals clashed again in 1973, when CMA successfully opposed SB 413 and CHA initially supported it. Subsequently, CHA trustees considered the views of organized medicine when developing a position on governmental regulation of health facilities. Partly owing to CMA opposition to consolidation of regulatory controls in a public-utility-like agency, CHA Trustees in 1974 amended the report of its Task Force separating rate regulatory and capital expenditure controls, to gain CMA support. More recently, positions of organized medicine and hospitals toward governmental regulation have grown closer as hospitals have backed away from support of public-utility-like facility regulation. It appears that the implicit objective of CMA actions has been to fight coordinated regulation of health facilities because it limits physician discretion and might be extended to the doctor's office. They have been successful in avoiding coordinated controls, leaving limited and fragmented regulation which they seek to contain and control. It is an interesting dilemma that rate regulation would probably strengthen the hand of the administrator in refusing demands for added services and equipment from the medical staff, but it would also limit his or her own discretion to expand services as desired.

CHA positions have been the result of consultation, conflict, and compromise between segments of the hospital industry. The Commission was created out of a consensus within the industry in favor of the Disclosure Act. This consensus broke apart when CHA initially supported SB 413. When federal price controls were lifted and the Brown administration took office, the CHA backed away from support of rate regulation; its position now appears more in line with those of UHA, Kaiser, and the Association of Catholic Hospitals.

UHA has generally opposed rate regulation by the state, fearing that regulatory agencies might end up regulating its profit margin and questioning its effectiveness. It also has opposed public-utility-like hospital regulation and, unlike CHA, favored exemption from Certificate of Need laws for facility replacement and modernization. Kaiser has always opposed rate regulation and sought exemption from Certificate of Need and other facility regulatory laws (e.g., reporting requirements of the Disclosure Act). Its opposition to facility regulation has in part been based on the view that the regulatory body would probably be predominantly influenced by fee-for-service community hospitals and medicine that would seek to stifle Kaiser's growth. The more recently established California Association of Catholic Hospitals began taking their own position on legislation when they decided that CHA no longer adequately represented their views. They have generally opposed expanded regulation. Reflecting changes in some of its major constituency groups, CHA's policy shift appears to parallel a more conservative posture of AHA, illustrated by its backing away from the recommendations of the Perloff Report.

According to industry sources, CHA's posture has moved from "cooperative advocacy" to "constructive opposition." "Cooperative advocacy" connotes support for expanded government regulation as in the public interest and in the long-range interest of the hospital industry. This posture, in the view of one industry spokesman, results in "poor representation of your constituency and your cause."

> Hospital administrators are fed up with being told they are incompetent and are increasingly opposed to expanded government regulation which they view not only as arbitrary but also as unduly restrictive of their ability to properly manage their own institutions . . . Rather than seeking to represent the broad public interest, the Association's role is to represent its constituency leaving to the legislature the role of defining the public interest through reconciliation of competitive demands by various groups and interests.

In the view of this industry source, UHA, Kaiser, and the Catholic Hospitals have been "saying things that hospital administrators want to hear," have stepped out front to take a united position on important issues of interest to hospitals, and now probably represent the prevailing view within the industry. They have challenged the industry's resigned view that increased government regulation is inevitable and that CHA should support and help fashion it. These groups recognize the likelihood of increased government regulation but feel the industry's interests are better served by a more adversary form of "constructive opposition" aimed at influencing government policy.

Their view is that governmental regulation will adversely affect the industry because government is such a large purchaser of care. Whether a government agency is bureaucratic (like the DOH) or nominally independent (like the Commission), it will be primarily concerned with controlling costs to the government. Therefore, in the long run, it is not in the best interest of the industry to favor increased government regulation since this will result in greater efforts to force arbitrary cutbacks in payments to hospitals. This coalition of interests presented a united front on AB 4001 and was successful in gaining amendments sought by the industry. It was also successful in helping to defeat Brown administration-backed rate regulation legislation. Recently, CHA appears to be functioning more like a consensus-builder for industry positions against government regulation than as the supporter of government regulation it once was during the late 1960s and early 1970s.

It is noteworthy that the CHA leadership has encountered more and more difficulty in gaining support for policies that would add to the regulatory burdens of its members. The Disclosure Act was a limited regulatory approach that the membership accepted only after extensive lobbying convinced them that it would not hurt the industry and was necessary to stave off more stringent regulation.

Later, in 1974, CHA leadership favored more extensive controls (e.g., the recommendations of its Task Force on Government Regulation), again tailored to meet industry financial requirements, but was unable to gain sufficient member support for them. Thereupon, in the absence of federal price controls and state pressures for rate control, the CHA stopped pushing its own regulatory program. The risks of regulation appeared to outweigh the benefits even though the Task Force program contained sufficient protections so that, if accepted by the government, it probably would have benefited the industry economically. Recent industry opposition to state rate regulation reflects growing sentiment against controls by powerful segments of the industry and the apparently declining influence of supporters of public-utility-type controls.

- *The unwillingness of the legislature to either expand or contract the Commission's powers in ways unacceptable to major health provider groups.*

(We do not assume that expansion of the Commission's powers is or is not desirable.)

Efforts to expand the Commission's health facility regulatory role launched by both the Reagan administration in 1973 (SB 413) and the Brown administration in 1977 (AB 1156) were defeated largely because of effective industry lobbying, especially in the legislature's fiscal committees. The Commission's 1975 economic stabilization proposal received no support from providers, but failure of this legislation was also due to the Brown administration's previous

opposition to expanding the Commission's role in cost containment. Proponents of such powers apparently do not make up an effective constituency and the legislature appears uncertain about the desirability of the proposed approaches. Provider groups remain strong in the legislature, as witness the recent announcement by the sponsor of the Governor's proposed legislation that he is dropping it in favor of a possible cost-containment initiative for inclusion on the November 1978 ballot.

The legislature has also been unwilling to either dismember the Commission or expand the rate regulatory role of the Department of Health--both moves being opposed by health provider groups. Efforts supported by the Brown administration to phase out the Commission and to have the DOH conduct a federally sponsored rate regulation study were defeated in early 1977, primarily because of legislative dissatisfaction with the DOH's performance.

- *The influence on the Commission of the gubernatorial administration during which it functioned.*

The Commission's fortunes have greatly depended on the Governor. Governors Reagan and Brown have made appointments to it and otherwise conditioned its political environment by their support or opposition.

The Commission was created and its powers expanded under the Reagan administration. It was designated the State Advisory Board to advise on exemptions from federal price controls. It was part of the Reagan "team."

When Governor Brown took office, the Commission was "benched." It was viewed as a holdover agency dominated by Reagan appointees and the hospital industry. It was ignored at first, and then efforts were made to phase it out of existence and encourage competitive efforts by the DOH.

The Commission responded by taking steps to ensure its survival. Its Chairperson sought to cooperate with administration and to suggest appointees acceptable to it. To allay concerns that the Commission was industry-dominated, she also unsuccessfully sought Commission support for legislation to make it a public-member body. The report of the Commission's Task Force on Short and Long-Range Goals, representing the Commission's most definitive commitment to cost containment objectives, appeared at least partially motivated by its members' desire to gain acceptance from the administration. When these efforts failed, the Commission fought for survival in the legislature. When the proposed phase-out of the Commission failed, the Governor finally made long-delayed Commission appointments, effectively taking control of it. The "new Commission" thereupon issued a policy statement that it was "part of the State Administration" and should play "an aggressive role within the Administration" to help formulate health policy and legislation. It supported Administration-backed rate regulatory legislation and was now, for the first time, accepted by the Brown administration.

The "new Commission" differs markedly from its predecessor. For the first time it has a majority of public members, several of them affiliated with consumer advocacy groups. The Commission has invited consumer groups to furnish direct inputs to its deliberations. Its new budget calls for appointment of a consumer liaison, and its policy statement champions more active public disclosure of the information it gathers.

- *The lack of involvement and interest by consumer groups in the Commission's work until recently.*

The creation of the Commission was in part sparked by the activity of a labor-sponsored health group, the California Council for Health Plan Alternatives (CCHPA), which lobbied for health facility regulation in the late 1960s. Consumers in general, however, paid little attention to the Commission's efforts to design a uniform accounting,

reporting, and disclosure system for hospitals and long-term care facilities; and after the Commission was created, the CCHPA turned its attention to other matters and then disbanded.

Other consumer organizations perceived that their participation in the Commission's work was unwanted during the Reagan administration. Besides, some consumers saw more important matters for their attention, since the Commission had no major regulatory functions. Even the public members on the Commission found the technical side of developing accounting and reporting systems difficult to understand and somewhat uninteresting. The opposite was true for the hospital and long-term care industry, which had a vital stake in those systems and willingly furnished technical assistance and advice. Primarily by default, then, the industry found its influence over Commission activities virtually unchallenged during its early years. Under Governor Brown, consumer groups have actively participated in the Commission's work. Labor and business organizations, as indicated by their support for Governor Brown's rate regulation proposal, have taken a more serious interest in cost containment legislation and may become an important countervailing influence to that of provider groups in the legislature. Consumer group support for an initiative measure suggests their willingness to mount a major political offensive on the issue of cost containment, something they have not been able to do effectively in the past.

- *The competition between the Commission and the DOH for regulatory power.*

When the Commission began to seek expansion of its powers to include rate regulation, CES control, and collection of nonfinancial health facility data, it collided with the recently unified DOH, which sought the same powers. Their struggle was contained during the Reagan years, but came out in the open during the Brown administration. Besides their bureaucratic interests, three factors influenced the struggle:

- Support for the Commission by providers who sought to expand the role of a "friendly" agency on which they had representation rather than see added health facility controls exercised by the state's major purchaser of care.

- The desire of the state's major purchaser of care to exercise greater control over rates charged by providers as a means to influence both state costs and the distribution of facility health care.

- Escalating criticism of the DOH in 1976 and 1977 by the state's Little Hoover Commission and key legislators, one of whom called on the Governor to fire the Director of Health.

The Commission lost the battle for Certificate of Need authority when 1976 legislation implementing PL 93-641 gave this power to the DOH. The conflict over health facility data collection resulted in failure of the two agencies to cooperate on the design of a system to minimize data demands on health facilities, and in failure to implement 1973 legislation establishing the Commission as the coordinator of health facility data collection for the state. The legislature defeated both the proposed DOH rate study and the Brown administration's effort to phase out the Commission in the spring of 1977, primarily because of their dissatisfaction with the DOH's performance. Criticism of the DOH prompted legislation to dismantle it, which was enacted with administration support in 1977 (SB 363, Gregorio).

Since new appointees have been named to the Commission, cooperation between the DOH and Commission appears to have increased. The breakup of the DOH will probably also change relationships between the Commission and health regulatory units in the executive branch. However, the seeds of bureaucratic conflict still remain, since several Commissioners have suggested that the Commission should assume Certificate of Need responsibilities that will be undertaken by the Health and Welfare Agency.

- *The effect of federal government actions on the development and implementation of state health regulation.*

Federal actions have set the parameters for state action and have influenced the positions taken by health provider groups. Federal legislation establishing price controls resulted in the Commission's assuming a role as the State Advisory Board (SAB) to the federal Cost of Living Council even before it undertook to implement its legislative mandated mission. The imposition of federal price controls, and the expectation that these controls would continue and that federal regulation of health facilities would inevitably expand with the passage of national health insurance (NHI), impelled California hospitals to support delegation of regulatory authority to the Commission at the state level. When federal price controls were eliminated and the likelihood of quick passage of NHI diminished, the pressure for state regulation dissipated.

The provisions of PL 93-641, the National Health Planning and Resources Development Act of 1974, not only provided for federal control of the entire health planning apparatus but also was a factor in the delegation of Certificate of Need authority to the DOH rather than the Commission. Once the Governor determined that the DOH would be the state's designated planning agency, the law and logic appeared to require that it also perform state Certificate of Need functions. This same Act and previous federal planning legislation (PL 92-603) authorized grants to states for studies and demonstrations to develop rate regulatory methods.

The availability of federal grants and contracts stimulated both state and CHA developmental efforts. It also ignited conflict between the Commission and the DOH. It prompted the CHA-sponsored rate regulation demonstration project (PIPE), and the competitive Commission and DOH rate and facility data proposals. The unwillingness of federal officials to intrude into state political decisionmaking

helped the success of the DOH projects. More important, however, the legislature's action not to allow federal and state agencies to make state policy without legislative review, and not to accept federal funds, has significant implications for federal-state relations. In this instance it signalled that the legislature refused to be by-passed when it believed important issues were at stake.

Federal decisions not to reimburse the state for increased Medi-Cal costs as part of the proposed PIPE project, and to tie federal funding for PIPE to the fate of the DOH projects, illustrate the dependence of grantees on shifts in federal policy. Federal grants to CHA for design of hospital accounting and reporting systems and rate regulatory methods demonstrate federal recognition that industry involvement in such developmental efforts is desirable.

The President's recent sponsorship of federal cost containment legislation has both stimulated and complicated state action. The announcement of the program dramatized the need for cost control, but it also gave rise to uncertainty over what rights and powers will be granted to the states. Provider groups have successfully argued that California should mark time until Congress acts.

POLICY IMPLICATIONS

Cost Containment Legislation

If past experience is a reliable guide, health facility regulatory legislation opposed by major health provider groups will probably not be enacted in California unless prompted by federal legislation. If Congress permits a state option that providers find more attractive than federal regulation, then a state program based on federal guidelines probably will be passed. The prospects of speedy Congressional action dimmed with the recent announcement by Congressman Rostenkowski that his House Ways and Means Health Subcommittee has postponed hearings on Carter administration-backed cost containment legislation (HR 6576) until February 1978. Rostenkowski said additional time would allow the administration to reexamine and modify its proposal

to strengthen public and Congressional support for it. He also called upon health providers to develop a *voluntary* cost containment program for implementation early in 1978.[1] Congressional delay and uncertainty about the outcome of their deliberations substantially reduce the likelihood that the state will enact a program of its own during the next several years.

Despite past difficulties and federal uncertainties, however, it is conceivable that California may unilaterally enact rate control legislation distasteful to providers, *but only if the Brown administration strongly backs it and a more effective constituency for it is mobilized.* There are some signs that a stronger coalition of interest groups favoring cost containment is developing, as evidenced by labor, business, and insurance industry support for Governor Brown's 1977 legislation. Commercial insurance carriers seem to fear government takeover of the insurance market because of unconstrained cost growth more than they fear the animosity of hospitals and doctors. Apparently, increases in health insurance premiums, which are eating up a larger share of both business profits and labor's gains from collective bargaining, are spurring business and labor to support cost containment.

Supporters of cost containment could promote a ballot initiative, as suggested by Assemblyman Keene, or they could choose to continue their legislative lobbying. It seems doubtful, however, that insurance companies, labor, business, and the administration can agree on the content of a 1978 initiative and lend it full support. Commercial insurance companies have not shown a willingness to provide financial support for an initiative, probably for two reasons. First, an

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[1] *Congressional Record--House*, November 2, 1977. See also Joint Statement by the American Hospital Association, American Medical Association, and the Federation of American Hospitals, November 3, 1977, in which spokesmen for these groups said they would develop a voluntary program.

initiative would draw them into open confrontation with providers without recourse to the negotiation and compromise afforded by the legislative process. If it failed it would probably be impossible to get a program through the legislature for several years. Second, they would run the risk that a technically imperfect proposal not subject to change might be placed on the ballot.

Because the governor has little incentive to incur the wrath of health providers during an election year, he is not likely to support an initiative, and labor and business groups are apparently interested in more important "bread and butter" issues than health cost containment. Moreover, potential supporters have not yet agreed on the language of an initiative measure. In sum, it seems unlikely that an initiative will even get on the 1978 ballot, let alone pass. It is possible that one motive of proponents is to spur providers to negotiate in the legislative arena. But if an initiative receives little support they may achieve the opposite result. Weak support for an initiative would probably deter legislative action, since it could well be interpreted as a reflection of weak political support for cost containment.

A key factor in any future political struggle over cost containment is whether provider groups will remain united in their opposition to such legislation. Their past successes suggest they will. Of course, if federal legislation is enacted or pressure for controls greatly increases, provider groups conceivably could choose to negotiate separately and thereby weaken their collective influence. Such fragmentation is possible, but improbable.

The difficulty of successful negotiations between the state government and California's providers is to be seen in their conflict over the following issues: (1) the makeup of the Commission; (2) equal payment by all purchasers (providers want equal rates as a precondition to regulation, while the government wants its costs contained); and (3) the payment method (i.e., budget review and approval of individual facility budgets, favored by providers, versus tight formulas supported by the government).

Even if the legislature established a health facility regulatory program, past experience suggests that in the long run the regulatory body might be more responsive to the interests of providers than of consumers. Also, since rate regulation methods now in use have not conclusively demonstrated their effectiveness in containing costs, it would be difficult to prove that more will be better. This does not detract, however, from the potential value of state experimentation to develop effective methods. California has pioneered in the development of regulatory approaches in several fields, approaches that have been adopted by other states and the federal government.

The Commission

The Commission has a public-member majority for the first time, and consumer advocates now make up a substantial share of its membership. The Commission has become more activist and consumer-oriented than its predecessor since Governor Brown made his appointments to it. As we have pointed out, however, inherent restrictions in the law severely limit what even a consumer-oriented Commission can do. It can collect, analyze, disclose, and recommend, but it cannot directly regulate health facility costs and charges. Perhaps the most useful future role for the Commission is to act as a "consumer watchdog," with technical competence to perform four functions:

1. Develop and more aggressively disseminate information on facility costs and charges, and publicize issues of interest to consumers. This information could be used by government, insurers, labor, business, other consumer groups and planners (e.g., HSAs) in determining how best to use their purchasing power and regulatory authority to influence the cost and distribution of facility services.

2. Conduct studies of hospital economics, using its unique data base to compare the performance of different hospitals. This will require evaluation of current reporting systems to determine the costs and benefits of collecting additional data (e.g., on case mix), changing reporting requirements (e.g., quarterly reporting), and performing sample audits to determine the accuracy of hospitals' reporting.

3. Study alternatives courses of action to produce cost containment and evaluate their effects. This would include tracking the results of various existing regulatory and experimental programs (e.g., rate regulatory programs in other states and federally sponsored experimental projects on rate regulation authorized under PL 93-641 and PL 92-603), exploring the value of altering market incentives (e.g., changes in the insurance system to promote use of efficient suppliers and encourage formation of HMOs), and evaluating the effect on hospitals of the Commission's public disclosure program.

4. Conduct its own experimental programs. The Commission might choose to conduct its own demonstration to test the effects of alternative rate regulatory methods in California. Such an experiment might resemble that proposed in the CHA-sponsored PIPE project. Legislation might be enacted in California mandating provider participation in such a large-scale experiment.

The Commission could help organize a more effective consumer/purchaser constituency to at least partially offset provider influence on the health facility regulatory process. For example, the Commission might serve as a forum where consumer, insurance, business, and labor groups define their common interests as a basis for coordinated political action.

It would seem that cooperation with the new Commission would be in the interest of providers, who might prefer to work with an aggressive Commission rather than see it pursue its developmental role without their participation. The degree of industry participation will, of course, depend on how aggressively the Commission acts to pursue goals that hospitals find unacceptable. The nature of its relationships with providers will be a sensitive matter for the Commission. If it takes an extreme adversarial posture toward the industry, industry resistance may hamper its efforts.

The initial performance of the new Commission suggests that it is less likely to be biased toward the regulated industry than was its predecessor. Whether this will result in better outcomes of the regulatory process remains to be seen.

The Consumer

The early history of the Commission indicates how consumers ignored the Commission and left the implementation of its charge primarily up to providers. One of the implications of this study is that consumer representatives should *pay attention to* and *acquire technical competence in* health facility financial affairs. The recent change in the Commission's orientation may help to counterbalance industry influence, but it is extremely important that consumers have access to technical competence. This suggests the need for the investment of public and private funds to support consumer-group-sponsored independent analysis of health issues.

The Physician

Regulation of physician behavior has been excluded from California health facility cost containment proposals, even though physicians make the primary decisions that generate costs; the main reason is political, since exempting physicians will make a regulatory program easier to enact. Rate regulation may be seen as a device to encourage hospital administrators to say "no" to their medical staffs, but this roundabout method may meet with mixed success. It does appear, however, that more direct involvement of the physician in cost containment programs is both necessary and desirable although it is generally not supported by organized medicine. According to one former CMA president whom we interviewed:

> Many within organized medicine have had their head in the sand. Doctors must be involved in cost containment. There is only so much money to go around and tough decisions have to be made. Medicine has engaged in quality of care rationalization. It has opposed cost containment because of fears that office fees would then be regulated. Quality and cost are related. Cost-effectiveness should be our goal. Medicine should help fashion and be part of a regulatory system that we can live with. This is not the prevailing view of organized medicine.

IMPLICATIONS FOR RESEARCH

The Commission's major accomplishment has been the development of a uniform accounting, reporting, and public disclosure system for California hospitals. Most observers say the system is a good one, but it has not been independently evaluated. We suggest that it would be useful to assess the system's effect on the cost and quality of health care in California through comparisons with other states that either have or do not have cost containment programs.

Theoretically, the public availability and dissemination of cost data might be expected to reduce costs by (1) encouraging price competition between institutions; (2) equipping large purchasers such as insurance companies and unions to bargain more effectively with hospitals; (3) allowing public agencies to allocate resources to more productive facilities and encourage consolidation of services, and (4) encouraging studies aimed at improving hospital productivity.

Specific questions to be addressed in an evaluation would include:

1. Did uniform accounting and reporting of hospital financial data affect the behavior of hospitals in any measurable way? Did it influence individual hospital planning or resource allocation decisions? What was the effect of making comparable cost data on hospital charges publicly available? Did disclosure exert any cost containment pressure on hospitals?

2. Were the data widely disseminated and used by purchasers of care and planning agencies to influence hospital charges or planning decisions? Did newspapers publish stories on local hospital costs? Were hospital reports used by large purchasers to bargain with hospitals over rates or to influence selection of hospitals to perform covered services based on their charges? Did HSAs use the data to make Certificate of Need determinations that would encourage more efficient use of resources and consolidation of public facilities? Did consumer organizations use the data to focus public attention on cost growth and exert pressure on facilities to contain costs?

3. Were studies undertaken aimed at economic analysis of hospital productivity, using disclosure data?

The data developed in response to these questions on the operations of a sample of California hospitals of different size, geographic region, and type of control could then be compared with data from similar hospitals in other states.

CONCLUSIONS

We have seven major conclusions:

1. *The health facility regulatory process involving the Commission as a key participant was biased toward health provider interests, but it is not clear that this bias has yet resulted in socially undesirable outcomes.*

The Commission fulfilled its primary task of producing a generally well-regarded hospital accounting and reporting system; and as for cost containment, there is no assurance that the proposed programs the legislature failed to enact would have been efficacious anyway.

2. *California is unlikely to enact major cost containment legislation in the near future.*

Past history indicates that major legislation in this field unacceptable to health provider groups will not be enacted. Moreover, delay and uncertainty surrounding Congressional action on President Carter's cost containment program further reduces the probability that the California legislature will adopt an independent program. In addition, the necessary support of insurance, business, labor, and the state administration for passage of an initiative measure has not materialized.

3. *Since cost containment programs in other states have produced uncertain results, California should be cautious about enacting comprehensive regulatory legislation in this complex field.*

Before promoting a regulatory program, state officials should carefully examine the results of experimental programs in other states, the likely effects of proposed cost containment measures in

California, and problems of effective implementation. The costs and benefits of proposed regulatory programs should be compared with market-oriented cost containment strategies such as encouragement of HMOs, financing incentives to promote the use of efficient providers, and other methods aimed at encouraging price competition.[2]

4. *The state can play a major role in developing and aggressively disseminating health facility data, conducting studies of hospital productivity, experimenting with alternative cost containment strategies, and focusing public attention on cost containment issues.*

The Commission, in cooperation with the federal government and other state agencies, can help fill an important need for knowledge-building in the cost containment field. Publicly available cost and price information is needed to focus attention on cost containment. This will help to keep pressure on providers to participate actively in the search for cost containment solutions.

5. *Consumer involvement can help counterbalance the influence of providers in the health facility regulatory process.*

It would be useful for consumers to define their common interests, actively participate in health facility regulatory decisionmaking and acquire technical competence in the field. The Commission may be able to help consumers achieve these objectives; it already welcomes their inputs to its deliberations.

6. *Future cost containment efforts should involve physicians.*

Since physicians make the primary decisions generating medical care costs, they need incentives to develop cost-consciousness.

7. *The implementation of California's uniform accounting, reporting, and public disclosure system should be independently evaluated.*

It will be useful to determine if the system has affected the behavior of hospitals, purchasers, or consumers in any measurable way.

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[2] For a review of market-oriented approaches, see American Medical Association, "Report of the Subcommittee on Medical Market Place," in the *Report of the National Commission on Cost of Medical Care*, Vol. 2, Chicago, Ill. (forthcoming).

Appendix A

ORGANIZATION CHARTS OF THE EXECUTIVE BRANCH OF THE CALIFORNIA STATE GOVERNMENT AND THE CALIFORNIA HEALTH FACILITIES COMMISSION

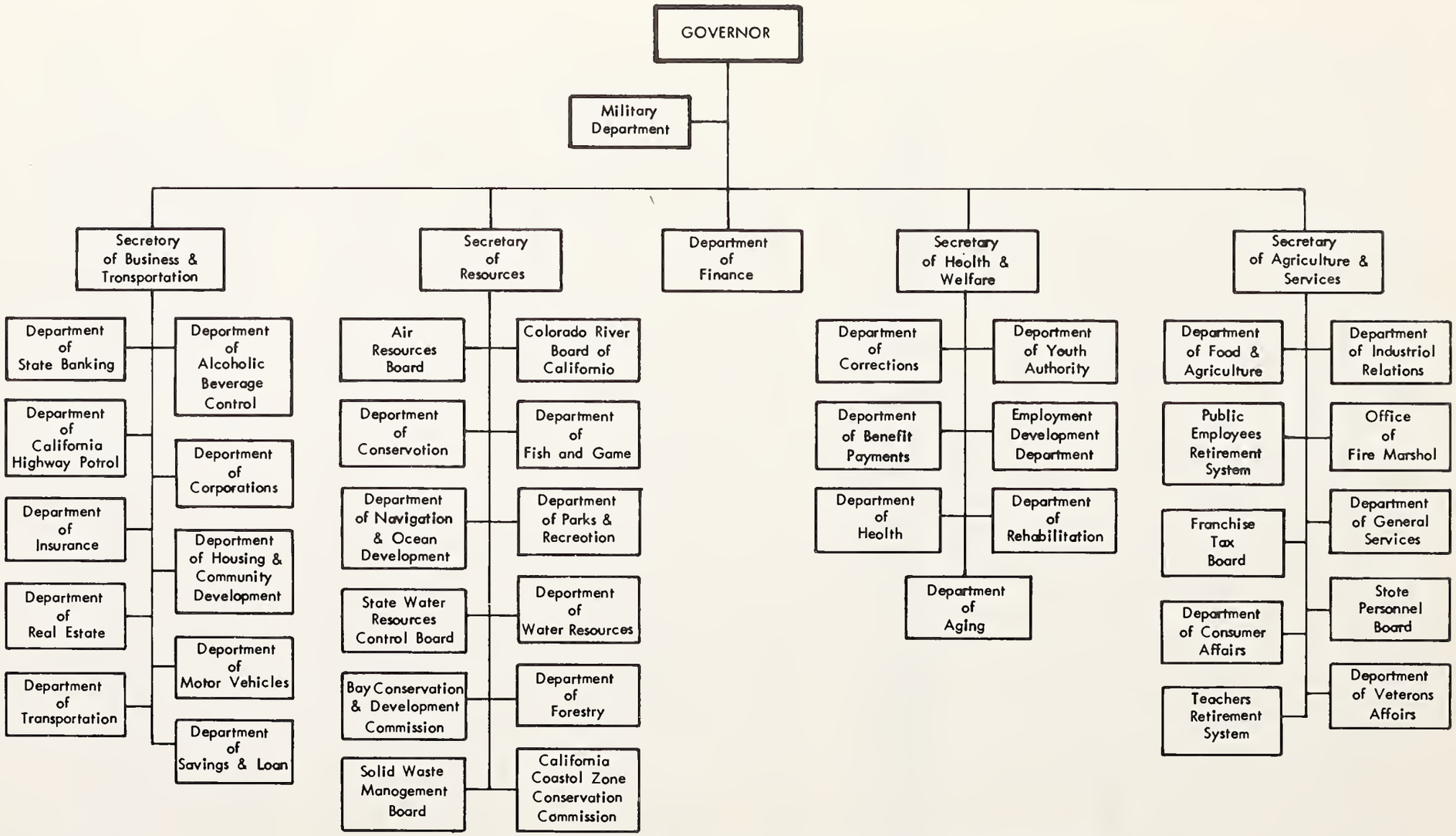

Fig. 1 — Executive branch of the California state government

Note: Figure includes only governmental units reporting directly to the Governor. Not included are such agencies as the Department of Educatjon, the Deportment of Justice, and the Public Utilities Commission, which ore headed by Constitutional officers. The figure reflects structure as of November, 1977.

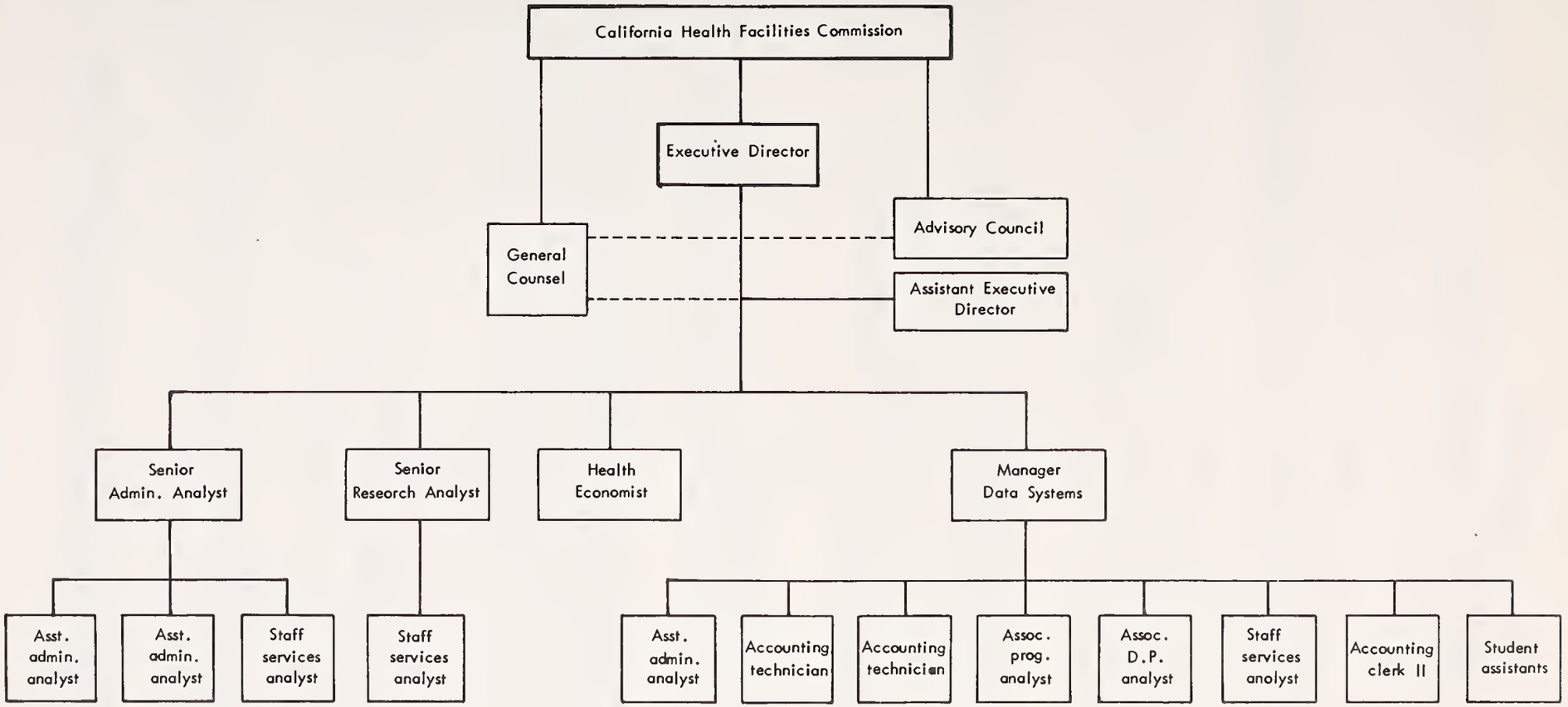

Fig. 2 — California Health Facilities Commission

Appendix B

CHRONOLOGY OF IMPORTANT EVENTS

1960

The Governor's Committee on Medical Aid and Health (the Egeberg Committee) calls for the establishment of a health planning system to control facility expansion.

1969

CHA-sponsored Certificate of Need legislation enacted setting up areawide planning organizations (AB 1340, Duffy).

Governor Reagan reelected to a second term.

1970

Labor-sponsored legislation introduced to comprehensively regulate health facilities (SB 1359, Beilenson).

CHA supports hospital financial reporting and disclosure.

Cost containment hearings held by Senate Health and Welfare Subcommittee on hospital rates.

1971

Federal price controls implemented.

Hospital Disclosure Act (SB 282, Teale) enacted creating the Commission and the uniform accounting, reporting, and disclosure system.

The Medi-Cal Reform Act (AB 949, Campbell) enacted, aimed at reducing eligibility and stimulating formation of prepaid health plans (PHPs).

Commission designated as State Advisory Board (SAB) to the Price Commission under Phase II of the federal economic stabilization program.

1972

Commission appointments made by Governor Reagan; Commission makes Advisory Council appointments.

CHA begins Hospital Effectiveness Demonstration Project to develop disclosure reporting system.

PL 92-603, the Social Security Amendments of 1972, enacted setting reimbursement limits and creating Professional Standards Review Organizations (PSROs).

1973

Commission adopts regulations governing uniform accounting and reporting systems for hospitals after public hearings.

1973 (continued)

Reagan administration-backed comprehensive health facility regulation legislation (SB 413, Beilenson) fails passage in its omnibus form; as enacted, it affects facility licensure and not rate regulation or Certificate of Need requirements.

CHA-sponsored legislation enacted authorizing the Commission to accept delegation of federal price controls; develop a hospital economic stabilization program; and set up a uniform comprehensive state health facility data system (AB 2123, Hayden).

The substance of SB 413 is almost wholly amended into another bill (AB 2477, Waxman), which rests in the Senate through 1974 and dies.

A unified Department of Health (DOH) is created pursuant to a Governor's Reorganization Plan consolidating various health agencies.

Commission adopts accounting manual.

California Association of Health Facilities (CAHF) sponsored legislation enacted expanding the Commission's role to include accounting, reporting, and disclosure for nursing homes and enlarging Commission membership (AB 4996, Ingalls).

CHA, the Commission, and the DOH begin federal health facility data studies; Commission and DOH Joint Policy Committee set up to coordinate studies.

1974

Hospitals required to implement Commission-mandated accounting and reporting system.

Federal price controls lifted.

Commission sets up Rate Review Subcommittee and holds public hearings on development of state economic stabilization program.

CHA adopts policy on government regulation based on report of CHA task force and Rate Review Subcommittee.

The National Health Resources Planning and Development Act of 1974 is enacted (PL 93-641).

United Hospital Association sponsored legislation (SB 1883, Song) enacted to exempt remodeling or replacement of existing facilities from Certificate of Need review.

1975

Governor Brown takes office.

Commission economic stabilization report presented to the legislature.

Legislation introduced implementing Commission report recommendations (SB 1107, Beilenson).

Legislation introduced implementing PL 93-641 (AB 1149, Keene, AB 2, Keene).

1975 (continued)

Legislation introduced to give Commission authority to conduct a demonstration rate-setting project (SB 1108, Beilenson).

Phase I begins of CHA-sponsored Prospective Incentive Payment Experiment (PIPE) to develop hospital budget and rate review methods.

Legislation sponsored by the California Association of Homes for the Aging (CAHF) is enacted increasing Commission membership from 13 to 15.

Hospitals begin filing disclosure reports.

Commission Reports Committee established to develop format for disclosure of hospital data.

Assembly Health Committee holds interim hearing on high cost of medical care.

1976

Report of Commission Task Force on Long and Short-Range Objectives is released, making recommendations for a hospital budget and rate review system; CHA opposes key recommendations.

Commission and DOH submit competitive rate study proposals to Social Security Administration (SSA).

Department of Finance concludes that DOH proposal should receive administration support.

State's "Little Hoover Commission" report recommends Commission be abolished and its duties transferred to DOH. DOH policy paper makes similar recommendation.

Department of Finance study recommends Commission be phased out; Governor approves Finance recommendation.

DOH notified it has been awarded SSA rate study funds.

Joint Budget Committee refuses permission to allocate federal rate study funds pending legislative review.

Commission adopts accounting and reporting regulations and manual for nursing homes.

DOH refuses to participate in Commission effort to develop single questionnaires to collect health facility data.

State legislation implementing PL 93-641 is enacted (AB 4001, Keene); Governor calls law "weak."

SSA is requested to fund Phase II of the CHA-supported PIPE project; CHA replaces the Commission as proposed rate-setting body with a Board to be appointed by the Director of Health. PIPE project is killed.

Legislation introduced to make the Commission a seven-public-member body and designate it as a Certificate of Need decision appeals body (SB 2162, Beilenson).

1977

Governor's Budget recommends phase-out of Commission and transfer of its duties to DOH.

Legislative Analyst recommends against transfer.

Legislative committees hold hearings on Commission and DOH rate study proposals and vote to kill DOH project.

Commission releases report containing first full-year inventory of data collected from California hospitals.

Governor Brown makes appointments to Commission; new Chairman and Acting Executive Director selected; Committee structure reorganized.

President Carter announces health facility cost containment proposal in special message to Congress; administration-backed cost containment legislation introduced (HR 6575, S 1391).

Commission adopts mission statement calling for more activist and expanded Commission role.

Nursing homes required to implement Commission-mandated uniform accounting and reporting system.

Legislation introduced to regulate health facility rates (AB 1156, Keene) and amended to gain administration sponsorship. Bill defeated.

Legislation enacted removing the requirement that the Commission's Executive Director have experience as a hospital administrator (AB 348, Maddy).

Legislation enacted breaking up the DOH into several health units (SB 363, Gregorio).

Legislation enacted placing some limitations on exemptions from Certificate of Need requirements (AB 245, Berman).

Legislation introduced to implement the Department of Finance recommendation to phase out the Commission (SB 985, Holden) is dropped soon after Governor Brown makes appointments to the Commission.

Appendix C

INTERVIEW LIST[1]

CALIFORNIA HEALTH FACILITIES COMMISSION

Jay Benson (Staff
Robert Beyer (Staff)
Charles Briggs (Staff)
William Caron (Advisory Council)
William J. Cole (Staff)
Gordon Cumming (Acting Executive Director)
Henry B. Dunlap (Member)
Gladden Elliott (Advisory Council)
Dr. Thomas Elmendorf (Advisory Council)
A. B. Halverson (Member)
Stoddard Johnston (Member)
Ronald Kaldor (Staff)
Allen Manzano (Chairman)
Alan McCready (Staff)
Einar Mohn (Advisory Council)
Robert W. Murch (Executive Director)
Dr. E. Kash Rose (Member)
Mrs. James Rowen (Member)
Mrs. Phyllis Smith (Chairperson)
J. E. Smits (Member)
Samuel J. Tibbitts (Member)
John Williams (Advisory Council)

CALIFORNIA MEDICAL ASSOCIATION (CMA)

Mike Allen
Bill Barnaby
Paul Brown
Dr. Gladden Elliott
Dr. Thomas Elmendorf
Dr. E. Kash Rose

DEPARTMENT OF FINANCE

Roy Bell
Al Loeb
Charlotte Ouwendijk
Jack Smith

DEPARTMENT OF BENEFIT PAYMENTS

Joe Cuccia
Jack Regan

DEPARTMENT OF HEALTH

Robert Beyer
Burt Cohen
William J. Cole
Dr. Saleem Farag
Bamford Frankland
Jim Gentry
Jerry Green
Lee Helsel
Robert Jackson
Henry L. Moody
Tom Moore
Julien R. Phillips
Ben Sifuentes
Layle Weeks
David A. Winston

HEALTH AND WELFARE AGENCY

Dr. Earl Brian
James W. Connor
Thomas J. Elkin
Dorcas R. Hardy
David A. Winston

GOVERNOR'S OFFICE

Gino Lera
George Steffes

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[1]Several persons are listed twice because they are or have been associated with more than one organization. Also, a number of those interviewed no longer serve the organization with which they are identified.

HOSPITAL INDUSTRY

Will Bishop (CHA)
Gordon R. Cumming (CHA)[2]
John Curley (Catholic Hospitals)
Emery B. Dowell (CHA)
Henry B. Dunlap (CHA--Commission Member)
Robert Erickson (Kaiser)
Robert Kirkpatrick (CHA)
James Lane (Kaiser)
Jim Ludlam (CHA)
James Smits (Kaiser--Commission Member)
George Steffes (UHA)
Samuel J. Tibbitts (CHA--Commission Member)
Paul Ward (CHA)
Carl Weissburg (UHA)
Bill Whelan (CHA)
Henry Zaretsky (CHA)

LEGISLATURE

Bill Abalona (Staff)
Assemblyman Dixon Arnett
Bill Barnaby (Staff)
Senator William Campbell
Kathy Creegan (Staff)
Tom Dooley (Staff)
Senator Arlen Gregorio
Assemblyman Barry Keene
Roger King (Staff)
Assemblyman John Knox
Dr. Paul O'Rourke (Staff)
Paul Press (Staff)
Senator John Stull
Assemblyman Tom Suitt
Senator Stephen P. Teale
Assemblyman Art Torres
Ken Wagstaff (Staff)
David A. Winston (Staff)

INSURANCE INDUSTRY

Emery B. Dowell (Blue Cross)
A. B. Halverson (Commercial Carriers--Commission Member)
Lew Keller (Commercial Carriers)
Lou Orsini (HIAA)
Louis Rivera (Blue Cross)
Fred Rothenberg (Blue Cross)

NURSING HOMES

Mike Baar (CAHF)
John Regan (CAHA)
Peggy Shuler (CAHA)
John Williams (CAHF)
Howard Worley (CAHF)

OTHER

Brian Dobrow, Golden Empire Helath Systems Agency)
Doug Engmann (Consumer Health Coalition)
Einar Mohn (Labor)
Tom Moore (Labor)
Dr. Fred Morrissey (U.C. Berkeley)

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[2]Cumming was appointed Commission Acting Executive Director in May 1977.

Appendix D

QUOTATIONS FROM INTERVIEWS

HEALTH DEPARTMENT STAFF

"The Health Facilities Commission was run by the CHA. CHA did their staff work and provided guidance. It was not an arm's length association."

"The Department supported the Commission during its early days. There was no problem with an industry oriented group because this was a good way to get the data needed. Later, when the Commission sought control over rates and certificate of need, there was a real problem with industry domination. The Commission was not really interested in cost containment. There was direct competition between the Department and the Commission and there was no way to work things out."

"The Commission was heavily influenced by the hospital industry. Knowledgeable experts from the industry ran the show and led the public members. They worked with the industry and not with the Health Department."

"The hospital industry has vested interests through membership on the Commission. It is hard to regulate yourself."

"The CHA wined and dined the Commission. The hospitals clearly viewed this as their Commission; they created it. They did the basic developmental work on most major programs involving hospitals . . . They molded the Commission's decision by their developmental work. The hospitals generally got what they wanted . . . The Commission was controlled by the hospital industry."

COMMISSION PUBLIC MEMBERS

"Just as the Health Planning Council was, the Commission has also been dominated by the health industry. Good lobbying helped them manipulate the system to maintain the status quo. The structure of the law dictated industry influence because of their membership on the Commission and Advisory Council and the requirement that a hospital administrator be the Executive Director . . . The industry had strong representation before the Commission, members on it, and technical capability. They provided the basic input to the Commission to fulfill its statutory mandates. Some key industry representatives favored increased government regulation and helped lead the industry in this direction."

"The cooperation of the hospital industry was essential to accomplish the work of the Commission. The industry was happy to have a Commission outside the Health Department to work with. A uniform accounting and reporting system did not seem a threat to some hospitals. Certificate of Need, if strong, is much more frightening."

"The Commission was primarily controlled by the hospital industry. Industry members and representatives did most of the work in developing the accounting and reporting, and in developing the Commission's economic stabilization program . . . The industry members were strong and dominant. Also CHA and UHA representatives were very strong and made major contributions to the Commission's work."

"The industry was primarily interested in securing a fair rate for hospital services from the government. They were *not* primarily interested in cost containment."[1]

"The Commission was set up to do a technical job. This was an apolitical task. The industry cooperated. The task would not have been well served by people who didn't know about the industry . . . There was tremendous disinterest by consumers and no consumer participation."

COMMISSION APPOINTEES FROM INDUSTRY

"The industry was the primary initial influence on the Commission. Industry leaders suggested the approach embodied in the Disclosure Act, and the industry took leadership to provide technical help to the Commission. Industry leaders also had quite a selling job to do within their own association. Industry expertise is necessary to develop a marketable system. An alternative would be to develop a system that is penal in nature which does not utilize industry expertise."

"The Commission has been heavily influenced by the hospital industry but it has not been a captive of that industry. The Commission has worked closely with the industry and there has been a feeling of mutual respect. The implementation of the Commission's program required close cooperation between the industry and the Commission."

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[1] A "fair rate" to the industry means a rate equal to that paid by nongovernment third-party payors.

COMMISSION STAFF

"The Commission has relied heavily on industry cooperation to achieve its objectives. Certain key individuals (in the hospital industry) have long realized that rate regulation is coming . . . They have wanted to shape the form of regulation which would be developed for the industry . . . The Commission was considerably more interested in getting a fair rate for hospitals than they were in cost containment . . . The public members tried hard but they were no match for industry spokesmen."

"The Commission has done an outstanding job in fulfilling the requirements of the law. This could not have been done without close cooperation of the hospital industry . . . The industry supported uniform accounting and disclosure in part because they felt the Commission would develop later to justify increased payments to hospitals from the government . . . It is true that one of the basic objectives of the Commission was to get a fair rate for hospitals . . . The Commission has also favored cost containment by endorsing the continuation of Phase IV of the federal ESP program and by the recommendations of its Committee on Short and Long Range Goals, which proposed a target for expenditure increases for the industry."

LEGISLATURE[2]

"The Commission was dominated by interlocking hospital, medical, and insurance interests. The positions espoused by the Commission were those of the industry, namely, support for equal payment by all purchasers and opposition to regulation by the Health Department because this would constitute a conflict of interest since the Department sets Medi-Cal rates."

"The Commission's economic stabilization report reflects CHA philosophy and the CHA task force report."

"The data developed by the Commission were long in coming and seemed to have, as their primary purpose, justification of the industry position of price discrimination by public programs. There is reason for suspicion about the validity of Commission data since hospitals have not been audited. Although consumer members talked a good game they were never really strong consumer advocates and had relatively little influence over what actually happened. The Commission was not oriented toward consumers and was never interested in consumer participation. Staff took guidance from the Commission and never took steps antagonistic to the industry."

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[2]Legislative interviews were conducted with members who chaired or staffed policy and fiscal committees concerned with health legislation. Their views are not necessarily representative of the legislature as a whole.

"Many legislative staff view the Commission as industry-dominated. The original legislation was sponsored by the industry, it was run by hospital members, and its executive is a hospital administrator. Its proposal to the Social Security Administration is essentially the same as that of the industry."

HOSPITAL INDUSTRY

"The hospital association was close to the Commission and pretty much dominated their operations. The primary method used by the industry to influence the Commission has been to take the initiative in developing and proposing ways to implement Commission responsibilities . . . The public members were pretty much led by what industry people said."

"CHA exerted tremendous influence on the development of the Commission's accounting and reporting system. This was a good thing. It would not have been done successfully without CHA support."

"The Commission has not been a tool of the industry. They have given industry a fair shake. They have been willing to listen and consider the industry's viewpoints and to accommodate to it and still achieve the objectives of the law. The Commission has established an open decisionmaking process and has not tried to run roughshod over the industry."

NURSING HOMES

"The Commission is not industry-dominated. It has, however, been responsive to the industry."

"The Commission has been willing to work with the long-term care industry."

INSURANCE

"The Commission appeared to be an instrument of CHA . . . CHA leaders were behind setting up the Commission and worked closely with it to achieve their objectives."

"The Commission initially was run by people from the hospital industry. The Commission was new and the public members were relatively ignorant and leaned toward the hospital point of view. Later, the Commission was less subject to hospitals and was more public oriented."

CONSUMER HEALTH COALITION

"Consumers have not been active because the Commission was dominated by hospital interests. They take positions similar to CHA. They study issues of interest to the industry. They have not been active in disseminating data. The Governor's failure to make appointments reinforced our view to pay attention to it."

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